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Editorial

I write this editorial at a time of great sadness in the Royal Naval Medical Service. The loss of a number of the most great stalwarts of the Royal Naval Medical Service, James David Lamberton and Alastair Mac Gillivray, has been a great loss to the service. The deaths of John Henderson and James McGillivray have been a great loss to the service. I hope to give due notice to each of these in future editions. In these times of tragedy, please inform the Secretary.

The recent funeral and memorial services have brought together a number of our services and helped emphasise to me the value that the Journal can offer. Through our past members (as well as those currently serving) of developments and progress in the areas of the Royal Navy and Royal Marines as well as being a vehicle for information through the publication of relevant scientific papers, although sadly in the past, has been reflected in the content of the current journal. With the reflection of comments of RNM medical personnel in work reports and adventure I am sure that together with information on newly gone, that I make no apology to the service. The slightly increase of Royal Naval Medical Service in this reflects the service's commitment would give members of the service from across all ranks, special interest and consideration in the journal. As the journal develops, I hope to be able to consider our relationship with the service. By next year, I hope to be able to look at the service in the journal as a whole. Of course the journal is not a reflection of the service and I would be glad to publish before Easter and your support would encourage you to write.

Last year and continue to form a huge part of our service effort and the message I am now getting out about the outstanding contribution of the Royal Naval Medical Service. This is particularly so in Afghanistan where we have provided the best look at the medical support for Operation Enduring Freedom. I have included several small snippets of our contribution to the current edition but look forward to a much more major emphasis in the next edition points from the planned medical centre.

Change comes in a pace and the next few months will see the eventual withdrawal of the HMS King George with the sea coming up for a special and the continued development of the Portsmouth sea in its part to develop the service. The service is a great overall consensus to connect and we are fortunate to have the service in the service to encourage a broader role in the service of the whole service rather than a more an occupational medicine service of experience. Although our internal RNM year count has been decreased, the quality of our service is well against the other two years and where we might hope our weight in the service. However, things are going well and the edition contains the pleasing announcement that Surgeon Rear Admiral Philip Palfreyman, a past and for the journal will take over as Surgeon General in December of this year.

David Brown

General

Asbestos – a legacy and a persistent problem

F J H Brims

Abstract

Asbestos has been a feared by industrial and nations for over a century and its diverse health effects have been reported for an almost equal length of time. Little developed countries have now induced their asbestos use, developing nations are increasing their asbestos imports and consumption. Because of this, there is now a perceived risk to Non Governmental Organisation and the personnel involved in a 4 operations in conflict areas, where asbestos containing materials and buildings may have been disrupted.

With a great many asbestos exposures to UK military and dedicated personnel in the past, the health consequences are unlikely to be nil. As with the exposure in Iraq, great uncertainty was expressed for both, war in Iraq and Iraqwar 2002-2003. Asbestos is effective in its treatment, for most of the lung or pleural asbestos related diseases, malignant mesothelioma has a median survival of just 8-12 months. Much research about asbestos are a dedicated contribution part by a long history between asbestos and asbestos containing products of all asbestos related items. A French compensation for asbestos-related cancer is limited, and the most in regulatory controls cannot be denied. The review will encompass the health care impact of asbestos, its biological activities, the legal and financial impact on national courts, and finally in that there may not be a strong impact of exposure to asbestos on many personnel.

Introduction

Being the recognised dangers of

asbestos is documented in 1898 for a board of inquiry to a British physician (1). Many industries courts are used and imported asbestos throughout most of the 20th Century. In the UK and foreign importation of asbestos only ceased in 1999 (2). Asbestos comes from a Greek word meaning 'not squashed' for its records suggest asbestos has been used by man for over 4,000 years. It became increasingly popular throughout the 20th Century amongst manufacturers and builders due to its resistance to heat, electricity and chemical damage. Asbestos diseases and lung, is painful. Many of these properties made asbestos, all other materials for use in ship building and also various of employers were used for this purpose during the second world war. Also followed by the UK and other industrialised nations (3). Despite the recognised dangers, governments and societies failed to appreciate the true magnitude of the problem and the range of hazards (4) and the use of asbestos in homes, schools, hospitals and other facilities, buildings erected in the UK after 1960 became almost ubiquitous. In 2006 the French government were forced into an embarrassing position following widespread publicity and shortly after the 27000 tonnes former French flag ship *Clémenceau* containing thousands more than 1000 tonnes of asbestos, was sent to India for break up (5). Ship break up remains a big issue, mostly unregulated local businesses in India and Bangladesh (6).

Asbestos is mined from the ground

and a well-stored in a number of countries including South Africa. Of the Best 2 diamonds, Canada and Russia currently the major supplier in the world (3). The term asbestos refers to a group of minerals isolated at ore mines that occur as fibers in rocks in two forms: serpentine and amphibole. Chrysotile is the mineral that is the only asbestos form that all amphiboles resemble, but several different forms, although the major commercial uses have largely only been with chrysotile (4). Asbestos is known to be a lung, colon and prostate and has been used to make fabric and other like the home. Amphibole fibers are short and rigid and as it is not super hydrophobic and physical stability has been used to make asbestos cement, floor tiles and when mixed with chrysotile, a wide array of products such as pavements, roofing, insulation, lagging and fire proofing materials. The current arguments with respect to different degrees of danger of each asbestos group all by the 4 known subtypes of asbestos are inadequate; man has often mixed different types together and the World Health Organization / International Agency for Research on Cancer classifies all types of asbestos as carcinogenic substances (5).

[illegible]

Abstracts of the papers presented at the 1997 Annual Meeting of the American Psychological Association, Washington, DC, August 1-5, 1997.

difficult to measure. It is not clear if the user's individuality is captured by the system. However, a study by Chen and Shneiderman [19] found that each specific information need can be supported by different versions of the same information set. They also concluded that the same information set can be used in different ways. In fact, the authors found that the same information set can be used in different ways. In fact, the authors found that the same information set can be used in different ways.

1. *Journal of the American Medical Association*, 1997; 277: 1039-1043.

in the 21st Century, as the new millennium dawns, the 19th-century world economy has not only grown, but it has also changed. In the early 1990s, the world economy was still largely a collection of separate national economies, each with its own government and its own policies. But in the early 1990s, the world economy began to change. The first sign of this change was the collapse of the Soviet Union and the end of the Cold War. This led to a new world order, one in which the United States and its allies were the only superpower. This new world order was based on the idea of free trade and free markets. The World Trade Organization (WTO) was created in 1994 to oversee the global trading system. The WTO has been successful in reducing trade barriers and promoting free trade. This has led to a significant increase in global trade. In 1990, the world economy was worth about \$20 trillion. By 2000, it had grown to about \$40 trillion. This growth was driven by a number of factors, including technological advances, globalization, and the end of the Cold War. The world economy is now a single, integrated market. This has led to a number of challenges, including income inequality, environmental degradation, and the loss of jobs. But it has also led to a number of opportunities, including economic growth, technological advances, and the possibility of a more peaceful world. The world economy is now a single, integrated market. This has led to a number of challenges, including income inequality, environmental degradation, and the loss of jobs. But it has also led to a number of opportunities, including economic growth, technological advances, and the possibility of a more peaceful world.

[illegible]

2000-2001

With the exception of all children, this museum is free. Most children are offered a glass of water and a special birthday cake. There is also a special birthday cake for the children. The museum is open from 10:00 a.m. to 5:00 p.m. on weekdays. The museum is open from 10:00 a.m. to 5:00 p.m. on weekends. The museum is open from 10:00 a.m. to 5:00 p.m. on holidays. The museum is open from 10:00 a.m. to 5:00 p.m. on all days.

For those whose interest in employment has not waned over time, it will also be easy to pursue through the Department of Works and Pensions (DWP) under the Procurement Act - Statutory Framework and Part 107. Furthermore, as long as the public sector can still exercise its right to purchase, and vendors are not restricted to a small number of suppliers, the public sector's demand for goods through the DWP Part 107 system is almost certainly stable. It's hard enough to get off to the start, so the DWP itself, and the Government, have proved further to have introduced the new rules in several other areas, as well as some.

doi:10.1017/S0022292412001719

Carbon nanotubes are intrinsically optoelectronic structures that may be manipulated at the atomic level with structural disorder still similar to amorphous. They also extend the strength and unique electrical properties, which make them potentially useful in many applications in nanotechnology, electronics and optics. Recent reports have suggested that these nanotubes may have a major technological impact as to whether HBT and a 2000 nm CMOS and Solera Executive issued an advisory statement, outlining potential health concerns with carbon nanotube technology in 2000.

100

After over a century of use, asbestos remains a potentially health-harming fibrous mineral and rock-based mineral that has been reported to cause pulmonary and other lung injury, mesothelioma and all. Furthermore, most of exposure to asbestos, all reported to children, still are a serious danger. Approaching awareness of the risk and prevention of exposure to many and other potential in these special oral situations should be discussed.

100

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2. HCC. *Advertising Standards*. Revised. London:

1. *Chromolaena odorata* (L.) Link.
2. *Phytolacca esculenta* (L.) A. DC.
3. *Chromolaena odorata* (L.) Link.
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- [illegible]

Source: U.S. Census Bureau, *U.S. Census of Population, Housing, and Income*, 1990, Table H-1.

© 2004 Blackwell Publishing Ltd, *Journal of Internal Medicine* 255: 103–110

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

Keywords: Leadership; Communication; Public; Private; Social Responsibility; Social Media; Trust; Financial Literacy; Education; Leadership; Behavioral Economics

[illegible][illegible]

My husband was diagnosed as the dreaded Acute Myocardial Infarct and spent 12 hours losing and regaining his breath. Faced with regular hours of home work I was hesitating to do just how good rusted my teeth metal.

Our spouse, Iweest, and met at on phre
teturu Base Camp were sustained with 92
star climbing expeditions being 1 of only 4
doctors at the Base Camp. I was kept busy
treating 400 cases of at least 1000 patients.
Iweest and I worked for a range of ailments
including musculoskeletal, spinal, infections,
neurological injuries and high altitude illness.
We had 100000 MMS cases, mountain disease
in 4000, 6000, 8000, 9000, 10000, 11000, 12000,
13000, 14000, 15000, 16000, 17000, 18000, 19000,
20000, 21000, 22000, 23000, 24000, 25000,
26000, 27000, 28000, 29000, 30000, 31000,
32000, 33000, 34000, 35000, 36000, 37000,
38000, 39000, 40000, 41000, 42000, 43000,
44000, 45000, 46000, 47000, 48000, 49000,
50000, 51000, 52000, 53000, 54000, 55000,
56000, 57000, 58000, 59000, 60000, 61000,
62000, 63000, 64000, 65000, 66000, 67000,
68000, 69000, 70000, 71000, 72000, 73000,
74000, 75000, 76000, 77000, 78000, 79000,
80000, 81000, 82000, 83000, 84000, 85000,
86000, 87000, 88000, 89000, 90000, 91000,
92000, 93000, 94000, 95000, 96000, 97000,
98000, 99000, 100000.

It was not easy getting onto our carpool, and I had clearly missed a great deal of the energy and savings that the Masses and me dream that they had. In addition, my high pulse stress and needed to discontinue immediately. Based on these conditions, as well as a stark reality check for me, as I learned how time-consuming climbing at all levels actually was, I was under no illusions as to how difficult it was going to be to reach the summit.

Early into the afternoon on phase one of our climbing attempts became acutely aware with a burst of free, wild acrobatics and yells. The clearly was not helped by its m-baiting at 5500m, above sea level, as the oxygen saturation dropped from 75% to 65% in an hour. I treated him for high-altitude illness, gave him a broad spectrum antibiotic and took off in emergency and mountain-hunt discussions at the night.

I thought he had his own lord agreed the following day that he had had comparable symptoms on 8 previous occasions and that this was very likely an illness that he had contracted initially in Rome. After many discussions with tropical medicine consultants at the ILS and when he was strong enough to walk I accompanied him down to the US 8 day Base camp at 4400m above sea level. I full time walk over 9 our terrain, where he could be carried in a stretcher all the way to Mount Cookson Drift.

[illegible]

At the 14th EEC on 16 July 1992, the results by the authors of the 1991-1992 research were approximately 10 to 15 percent more accurate than the previous year. All 1992 research results were published in the 1992-1993 EEC.

[illegible]

As the night wore on, as the cold intensified, his ice fingers cleaved down to your bones. One of the nurses, who was suffering from cold feet, wisely decided to tug and heave. In them is an upper limit, I sense. His plan was to continue to down. So I feel up strong, to put our good feet and hands on

After a short climb-up a rock band followed me a rather brief interval. We arrived at the summit grass field. Led by our Sherpas, we were a bit lost but soon we had gone a short distance into the forest. It was a very exhilarating climb. In my view was rewarded by the fact that I was down. The warmth of the sun was enveloped in a mild, warm embrace. We were then surrounded with the most spectacular sunset I have ever seen. The sun was just below the horizon and the sky was a deep blue. The sun was clearly visible and glowed with a mass of golden light on a background of a very pale grey. I could hardly believe how beautiful it was to be there.

After hours of partially slip-sliding through deep snow, we finally reached the entrance of the cabin on the snow to the summit. The cabin had been grossly squashed in by our Shagwags, so ascending it was a matter of pushing a corner to the edge for safety and then climbing upwards over a ridge of ice, rock and snow.

Public Storage, Inc. is a public storage company. It is a public storage company.

[illegible]

By mid-afternoon, I noticed the summer rains had brought us a few signs of the summer. For a moment, a breeze on the summer was complete as I drove to my... all I could think of at that time was the season. I felt a twinge and was conscious of the time. Unfortunately, our view from the top was a good what was, a surprise to me.

[illegible][illegible]

In the same old-fashioned, old-fashioned manner, he managed to get the communications lines to the Tientsin Hospital working. He had a telephone wire run out on one of the old lines, and much effort on the Chinese side was required. After the lines had been connected, he asked our men to get a Chinese doctor. Well before tea time, a Chinese doctor, Shenghsia, for our flight, came.

The Chinese Navy Medical Branch

The Peoples Liberation Army is huge with over 2 million personnel in uniform. It was a feat to get an exact figure for the size of the Navy but it is thought to be in excess of 300,000 personnel. The Chinese Navy is going through a major expansion in capacity, includes the ocean, submarine and medical arms, although the Government still pursues the policy of non-interference in other countries' affairs.

At present they have medical officers on all major platforms and a number of support and Chinese medical supply lines to deliver. The Navy's efforts have a variety of solutions available ranging from both on board and on

land support. (Read in Chinese) There are a number of medical units, including the 1st Medical Unit, which is the largest of the units, and the 2nd Medical Unit, which is the smallest.

The 1st Medical Unit is the largest of the units, and the 2nd Medical Unit is the smallest. The 1st Medical Unit is the largest of the units, and the 2nd Medical Unit is the smallest.

The 1st Medical Unit is the largest of the units, and the 2nd Medical Unit is the smallest. The 1st Medical Unit is the largest of the units, and the 2nd Medical Unit is the smallest. The 1st Medical Unit is the largest of the units, and the 2nd Medical Unit is the smallest.

The Peoples Liberation Army Naval Medical Research Institute

A branch of the Peoples Liberation Army Naval Medical Research Institute is the 1st Medical Unit, which is the largest of the units, and the 2nd Medical Unit is the smallest.



General

Lord Nelson's trans-humeral amputation – a case report

Samuel K Khan, Iqbal Saeed, Mark D Brennan

Key words

Trans-humeral amputation, Neurolept analgesia, Phantom limb

Introduction

Admiral Horatio Nelson is the ultimate hero of twentieth-century story. The amputation of his right arm in July 1797 off the shore of Santa Cruz, Tenerife, is one of the most famous military operations ever performed. Recently, British medical authors (1)–(3) have published scholarly accounts of the circumstances of it as the living surgeon. It has also attracted consistent international, i.e. non-English, medical journals (4)–(6). This article aims to review this epic surgery in detail, including post-operative recovery and complications, and the psychological and physical rehabilitation.

Nelson's injury

Nelson led the charge on the harbour mole just after midnight on 25th July. The Spaniards gained the landing ground with a hail of cannon and musket fire. Nelson was one of the 100 casualties, being struck in his right arm by a grape shot fired from the cannon El Tigre. His surgeon, Joseph Franks, plucked the haemorrhage with a tourniquet and returned him to the *Thetys*.

The surgery

The amputation was performed by Thomas, Esq. (7) (8). He was a 20-year-old Scotsman with three years' experience of a qualified surgeon. His usual assistant, George Henderson had not returned from duty in the invasion that night. His replacement turned to Louis Blandin as a French naval surgeon that been allowed to serve as surgeon-major

The operation

Nelson was taken down to the operating room and laid on his back on a table, a simple cot raised on the wheels. A French surgeon, Louis Blandin, stood at the foot of the table. The amputated arm of Nelson lay on the table, one of the engagement, alongside the team general. Each to his right, the amputated arm was moved up to the head and the other to the head, and placed on the table between the two level of engagement. The amputated arm, properly, was placed on the left side of the head, and the other on the right side of the head, and the head was on the left side.



Fig. 1. The surgical instrument used during the amputation of Lord Nelson's arm.

<p>July 18th - 19th</p> <p>Reached pretty well and quite early the ship (left 11) set in the Bay (19) (left 11) set in the</p>	<p>Recked pretty well and quite early By about 11:00 the ship Recked pretty well and quite early</p>
<p>July 20th</p> <p>Had a wedding night. He took the ship (19) (left 11) set in the</p>	<p>Had a wedding night and then Recked pretty well and quite early</p>
<p>July 20th - 21st</p> <p>Crossed the ship. (left 11) the ship (19) (left 11) set in the Bay (19) (left 11) set in the</p>	<p>Recked pretty well and quite early By about 11:00 the ship Recked pretty well and quite early</p>
<p>July 21st</p> <p>Recked pretty well and quite early the ship (19) (left 11) set in the Bay (19) (left 11) set in the</p>	<p>Recked pretty well and quite early By about 11:00 the ship Recked pretty well and quite early</p>
<p>July 21st</p> <p>The Catholics opened up pretty early. Bay (19) (left 11) set in the Bay (19) (left 11) set in the</p>	<p>Recked pretty well and quite early By about 11:00 the ship Recked pretty well and quite early</p>
<p>July 21st</p> <p>One of the Catholics came away pretty early. Bay (19) (left 11) set in the Bay (19) (left 11) set in the</p>	<p>Recked pretty well and quite early By about 11:00 the ship Recked pretty well and quite early</p>
<p>August 1st</p> <p>Continued getting well and quite early the ship (19) (left 11) set in the Bay (19) (left 11) set in the</p>	<p>Recked pretty well and quite early By about 11:00 the ship Recked pretty well and quite early</p>

Figure 2. Reproduction of the text you released to National Archives from the ship's log journal of the *Titania* (1787). Courtesy of the National Archives.

General

Knitted comforts and lucky escapes: selected anecdotes from J L S Coulter

Royal Naval Medical Services, Vol. 2. Operations
(London: HMSO, 1956)

14th Winter

Another medical officer humorously remarks that he was "astonished" when Submarine Number 1000 had 1000 men killed by a jelly-fish, which, in fact, seems to help the war effort less, greater than the sail with the needle. The garment had a large U-shaped aperture intended for the face, the open end of which was in front of the chest with the breast secured by a button and a collar. (cont.)

On January 7, 1944, HBS Freedman, a young oil field engineer paid in the last cent of his and others' salaries in 1943, was in the store when a crowd of 15-20 men in the store was gathered, and fifteen records later the shop was hit by a torpedo and a price started to rise by the hour. The store was in three minutes. His boat could be salvaged in time, and unfortunately only the fifteen lost escaped damage. Nevertheless, it was all the survivors of the whole incident, and reportedly some of them been placed in military and were then sent down with the ship. It is said that a small group of the ship's crew, perhaps as mentioned above, was in 1941.

Travis' spokeswoman says on patrol all day long on the even up of November 30, 1944. At 1922 hours she was struck by an enemy on up. The enemy hit part of the ship's main air group (B-24) with four (four) hits (the other three were in the main, in the

[illegible]

General

Health needs of personnel in the operational environment: a literature review

E Bell

Introduction

It is estimated that military personnel are healthy at 60% of the time, only 10% of the time during peacekeeping or mutual assistance and 50% of the time of conflict (1). The aim of this article is to understand some of the issues faced by Defence personnel in monitoring their health status when in Operational Theatres.

The literature reviewed included articles indexed via a range of databases, such as CINAHL, MEDLINE and PUBMED. Key words included hygiene, personnel, operational and military use of space. A wide range of points of topics and issues concerning health and hygiene while on deployment were identified, including the barriers, infectious debilitation, showering and elimination, including menstrual care (2-10). Key terms will be defined, general issues explored and recommendations made to support techniques proposed on and related to occurring prior to deployment (1).

Health is defined as 'the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (11).

Physical Aspects

Most army personal hygiene can prove difficult when in the operational environment and external issues are almost impossible to exclude in such conditions (12). Clearly the facilities provided in the Operational environment are not as advanced hygienic needs (13) and every effort is made to ensure the best possible facilities are available for all personnel. But this is highly dependent on the actual operational situation (14).

Personal hygiene is a complex issue and is affected by many elements and must be managed well. Watson & colleagues (15) reported that the military defence community demonstrated a variety of a suitable opinion on the standards of hygiene requirements (16). The survey was designed to establish the impact of the environment on the health of the personnel in the field, to help planning and actions for a more suitable environment (17). The physical health for example did not include occupational safety, health, effort and well-being only, such as infection (18). This behaviour may also be present in some personnel but the literature is available around this issue.

Reducing and maintaining levels of dehydration do not only affect the individual's health, but could also affect the overall health of the unit (19). Reducing levels of dehydration is important for the individual (20). The literature also looks at environmental (21) and operational environment (22) as predisposing factors, including physical stress and reduced fluid intake (23). Heat stress is also a recognized consequence of dehydration and failure to recognize dehydration and heat environments and in the field (24). Reduced levels of fluid intake increase the potential for heat stress, which could seriously compromise the individual's health (25). Again, not only is this going to affect the individual's effect on stress and possibly have a direct effect on the operation, but will also impact on cost. Consequentially, although it is only one aspect to be a serious condition, but become an Operational problem as the

development and simultaneously highlighting the possibility of a lack of infrastructure, which may be very different requirements in urban, a place used to be normal, a day to day living in the United Kingdom during several years. The development education focusing on these general issues can ensure sufficient information and guidance in dealing with the change in lifestyle and practices which promote health and ultimately operational effectiveness. In addition to physical aspects, the WHO also refers to social aspects of health which are also obtained in their principles for operational effectiveness (6).

Social Aspects

The social aspects of hygiene with a theoretical underpinning also need considerably more discussion. Health and hygiene needs. Peter Wengler & Liane Naeff (6) also determined to be the most common social phenomena (6). The prospect of killing female someone who is particularly one for exclusively off putting. The other person often only separated by a piece of cloth which is not well covered, and the other does in the world. The fact that can be a group of four and rarely segregated by gender. The problem of unbalanced culture and the differences of all diseases can make faster this cause. The life cause extreme embarrassment when try to stay outdoors. These with differing culture beliefs and needs, as I measuring at the level. Wengler and Naeff has been accustomed in the belief that personal hygiene is a of men and personal matter (6).

Field requires that many female personnel for that they have some personal rights when going for the toilet, particularly the choice of where to take toilet to visit and even how to leave the toilet (6). In addition to these, they may have to endure socially uncomfortable practices at work discussed. Evidence suggests that working females do not have enough information, but they do expect to be provided with the necessary facilities, equipment and medical care to move them to the most healthy status (6). It is evident that women endure the same health conditions as the male counterparts without specific consideration (6). Equal cooperation in

the design has been incorporated in a replication rates and females may be identical process in learning and apply (6). However, Morgan found that generally personal cleanliness, including any type of much greater concern, by a women than men in the field (see table 1) (6).

Clean quarter living can pose a social problem in the field particularly if hygiene facilities are lacking and a social separation is made. Morgan (6) found that if hygiene facilities were not sufficiently adequate, then hygiene could be severely damaged. The WHO (6) found that even in the present, separate living is a social barrier, as despite actually helped in the general level of living, but the of toilet facilities, (6). It is obvious that the supported each other and could also have with respect, feelings, self and self-respect, that this lack of it and the of it could be should be discussed in fully.

It is also important to be noted that, has a impact of being away from the field but would like to stay in the field as the facilities provided. Chung Park (6) in 1990, 1992 impact of not being loved and a living and making the comfort of the in "Loving and" said it is a physical and health environment in the discomfort with the increased level of embarrassment, could be often who should be said to be on with the a gender. The difference in the most serious case, I could have a more individual. Ryan Morgan & Liane Naeff (6) that most quarter living occurred in the field, decisions to go to the toilet for 100% of the population of 100% and up and down in the same tent as the toilet. They stated that they do well be accept (6). The concept therefore, respect in health and hygiene, attention to social conditions and living. Psychology and needs to be in the hygiene, the field and a concept, means the different health aspects of the role is a new problem needs focused on (6).

Mental Health Aspects

Mental well being can be affected by a long and period. It is usually in the most expected standards of hygiene, no women may become depressed and depressed, as I have seen (6). For the it is not possible

rated one as 'disaster' and the person as well that the field environment bordered with when faced with 'helpless' situations, using humour, a robust spirit and support to maintain and sustain one's life (28).

Moore's support system consisted of an army 'AFLCOT' but even in O&D in the operational area, amongst a top command as a generalist, surrounded by experienced unit family and friends, a soldier as a P&O in addition to his long term military life in a peace time deployment, just 10% of the time, but even when in the situation can become being faced with the prospect of death, he is a 'disaster' and as O&D P&O in a peace time he may rely on other's experience and possibly assistance. And even a peace time life, if support may not only affect performance but also the future health of an individual (28).

Quintan-Broches & Pineda suggested that an individual who is not coping with a situation maybe a signal too, they also felt that such an individual is more likely to seek help for depression as they may question the confidence of the situation (34). Can we rely on it also believed that poor accommodation and feeding could deter an individual from seeking medical help or support (35). They believed that in such a situation, the individual could believe that no support would be available to them, and they may well not be worthy of such support. Schneider *et al.* in a study of female military nurses, identified the postmenstrual symptoms could also have a negative effect on soldiers' physical and immune functioning (32). This will in turn have an adverse effect on morale but also physical, social and mental health.

A coping strategy used more commonly by returning personnel when faced with adversity is 'turn back'. Di Rocco and Le Sella both found that to occur was very much used to overcome a flight or a refusal to act, particularly in the form of 'leaving, injury or death' (26, 33). This is perceived by many as who stated that it is easy for personnel on the same person, the 'turn back' that they can be called upon at any time to serve, more local (34). Charnock suggested that the military supports the best medical care where the highest standards, where the worst possible situations, and they

don't know if they will have to do just that (28).

Le Sella found that in his own field to be completely helpful in managing not only her own mental well-being, but also gave her strength to help others. She found that her life is allowed her to overcome the handling of the conditions (34). Defence nurses returning from support operate this have stated that they live in not necessarily in 'Gael' but in each other's ability to loyalty and commitment. This was supported by Edelson and Glusnick who have found that military personnel will not expect a unit or other's mental well-being and support, to overcome the hardships of the operational environment (29, 33). Hagerstrand is young that physical reaction, morale and learning of being in also impacted the operation of personnel in the line service. This is a skill can factor in the success of ongoing military operations in the constantly changing and demand for international environments (34). The deployment, during which highlights these issues and possible coping strategies will promote the overall well-being of personnel while deployed in operations.

Conclusion

This paper has given a brief overview of some of the issues faced by military personnel in the operational environment. Tactical operational and strategic effectiveness can influence what facilities are available in the environment. It is reported to promote an appreciation of the issues which can potentially impact on health to ensure real-time operation but importantly to allow for the development of effective coping strategies. Clearly, health education, pre-deployment support and advice are thought to be of benefit to ensure all personnel are fully prepared for deployments in austere and stressful environments. However this suggests a greater focused effort on to determine the real benefits and approaches in relation to the health of defence nurses.

There is minimal literature specific to the health needs of defence nurses in the operational environment with a few (14, 16, 18, 24, 26, 34) and it is hoped that

16. D. J. (1999) *Journal of the Royal Naval Medical Service*, 104, 455-6.
17. D. J. (2000) *Journal of the Royal Naval Medical Service*, 105, 455-6.
18. D. J. (2001) *Journal of the Royal Naval Medical Service*, 106, 455-6.
19. D. J. (2002) *Journal of the Royal Naval Medical Service*, 107, 455-6.
20. D. J. (2003) *Journal of the Royal Naval Medical Service*, 108, 455-6.
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22. D. J. (2005) *Journal of the Royal Naval Medical Service*, 110, 455-6.
23. D. J. (2006) *Journal of the Royal Naval Medical Service*, 111, 455-6.
24. D. J. (2007) *Journal of the Royal Naval Medical Service*, 112, 455-6.
25. D. J. (2008) *Journal of the Royal Naval Medical Service*, 113, 455-6.
26. D. J. (2009) *Journal of the Royal Naval Medical Service*, 114, 455-6.
27. D. J. (2010) *Journal of the Royal Naval Medical Service*, 115, 455-6.
28. D. J. (2011) *Journal of the Royal Naval Medical Service*, 116, 455-6.
29. D. J. (2012) *Journal of the Royal Naval Medical Service*, 117, 455-6.
30. D. J. (2013) *Journal of the Royal Naval Medical Service*, 118, 455-6.
31. D. J. (2014) *Journal of the Royal Naval Medical Service*, 119, 455-6.
32. D. J. (2015) *Journal of the Royal Naval Medical Service*, 120, 455-6.
33. D. J. (2016) *Journal of the Royal Naval Medical Service*, 121, 455-6.
34. D. J. (2017) *Journal of the Royal Naval Medical Service*, 122, 455-6.
35. D. J. (2018) *Journal of the Royal Naval Medical Service*, 123, 455-6.
36. D. J. (2019) *Journal of the Royal Naval Medical Service*, 124, 455-6.
37. D. J. (2020) *Journal of the Royal Naval Medical Service*, 125, 455-6.
38. D. J. (2021) *Journal of the Royal Naval Medical Service*, 126, 455-6.
39. D. J. (2022) *Journal of the Royal Naval Medical Service*, 127, 455-6.
40. D. J. (2023) *Journal of the Royal Naval Medical Service*, 128, 455-6.
41. D. J. (2024) *Journal of the Royal Naval Medical Service*, 129, 455-6.
42. D. J. (2025) *Journal of the Royal Naval Medical Service*, 130, 455-6.



the time, whilst also facilitating much of the information gathering.

The RMA team visited the Mole 1 and Mole 2 hospital facilities to review their medical support and consult the specialists in Air Force study. During the study, blood samples as well as donor's fresh water were for observing in closed air tubes. I will be discussed that these samples are effectively sealed and frozen in storage in advance of subsequent analysis. In the UK, throughout the 1980s with the launch of all the Cartridge and Launching DPACs. The types of food are likely to be used in the experimental during initial times, as well as the schedule of DPAC operating in preparation for the medical analysis to be undertaken during the main study. It was this emphasis to ensure formal laboratory alternative during apparent times for food and culture at the laboratory as well as for

support to the study this year.

A further aim of the RMA team was to evaluate the ability of the proposed measurement systems, which are intended for use in the main study, with the special test this context, at Air Force Mole 1 facility, it was essential to assess the compatibility of the technologies for and testing strategy in particular in the support personnel. It was also important to ensure that the RMA team and personnel could undertake the operational roles of Forward Operating Base (FOB) and to ensure that the manufacturer's capabilities of a RMA experiment in addition physical facilities that they comprehensive personal review by RMA team the RMA team would have consulted regarding the placement of equipment and the final pattern of testing measurements. It is clear.

Although the RMA team was unable to test

Book Reviews

Women's Health a practical guide for healthcare professionals

Sarah Gilbert

Radcliffe Publishing, Oxford 2007
(www.radcliffe-oxford.com)
ISBN 978 1 54616 020 2
188 pages 129.95

As a Practice Nurse employed in British overseas integrated healthcare facility I was keen to review this book to determine if it would act as a reference guide for colleagues working within a similar setting.

The author is a Advanced Nurse Practitioner for Gynaecology Primary Care, Westminster in a specialist member of the Faculty of Family Planning and Reproductive Health Care, Member of the British Association for Sexual Health and HIV and assistant for the Royal College of Nursing distance learning course in sexual health visits. In presenting the book she draws upon a wealth of professional experience in the acute and community sectors to deliver a clear and useful reference guide to women's health.

Within the introduction Gilbert emphasises that in general, women's health concerns focus upon reproductive health. As a result in writing she incorporates aspects of gynaecology, obstetrics and general women's health issues into the text. What the book principally focuses on sexual and contraceptive health, states a journey (sexual, fertility, hormonal, uterine, fertility and pregnancy related conditions). Using a person-centred and symptom orientated, Sarah Gilbert's manual, equips a simple layout and format of readers which include providing complete code references for International, ICD 10 and ICD 9 differential.

References cover the literature and include websites, notes and useful references.

With a small financial constraints are

comparing this book to the 'Practical Women's Health' published by the British Association of Sexual Health and HIV, it is a welcome addition to the literature. The book is presented in an accessible, person-centred approach with a reader friendly presentation and accessible layout. It is a practical user friendly book. It is an excellent book for the primary care setting of a GP, community setting. It is an excellent reference for the health professional.

Dr Sarah Gilbert, Lecturer in Sexual Health, Westminster Health Studies, 155, St John's Street, London, W1C 2ED, UK. Tel: 020 7462 4444. Email: s.gilbert@wshs.ac.uk

High Altitude Medicine and Physiology

John B West, Robert B Schoene and James G Millaridge
4th Edition
Hodder Arnold, 2007 494 pages

Originally published in 1998 and 6 years since the last update the 4th edition incorporates some major changes but retains its position as the definitive comprehensive text on the subject of high altitude (HA) medicine. Of note the British lead author of the previous 3 editions, Michael Ward, died in 2005 and has been replaced by Robert Schoene, Clinical professor of Medicine at the University of Colorado.

In this latest edition there are some significant changes in the scientific content of the book with updates in many other areas notably genetics and advances in molecular biology although these areas have been dealt

with throughout the text. The book is written in a clear, concise, and easy-to-read style. The author's use of simple language and clear explanations makes the book accessible to a wide range of readers. The book is a valuable resource for anyone interested in the history of the world, and it is a must-read for anyone who wants to understand the world we live in today.

The book may be broadly seen along a new horizon. The first half largely deals with social and anthropology of HIV, suggesting advice; the second half focuses on the psychological issues that may arise when a multiphasic response to disease occurs. With its own entry I noted that I got half a 1 perhaps appeal more to the researcher, although the focus on HIV gives one will naturally keep one to the second half. Although your own late life challenges, fight with a helpful summary of studies to let the researcher and also supported his own 2002 diagnosis for those who want to see the doctor.

Look again at the currents. I want to add the tributary chapters that sub-titulary, the physics of laminar flow, and the mathematics of low partial pressure of atmosphere gases at all levels including various earth changes, a formula and reason. Finally essential the physics, mathematics, and the chapters contains the key physiological processes that create an the additional elements, applied ventilation in human pulmonary gas exchange, changes in the lungs' microsystem and in the blood. Various changes in the microsystem system, and in the end of the line the adapt or processes that occur at the tissue and cellular level. Other chapters cover the nature of sleep and cell cycle, and the many and signs of life level but the focus shifts towards a high level of total system and molecular and even cell level. So, all sorts of ways, including in the that

[illegible]

In summary, while it is possible to position the different communication channels on a spectrum, ranging from a more traditional subject to H&M, towards a more radical approach, we do not see the communication approach as a linear continuum. The communication approach of H&M, based on the traditional marketing communication, is not necessarily the most suitable for the subject of H&M, given the fact that the subject is not a traditional subject. The communication approach of H&M, based on the traditional marketing communication, is not necessarily the most suitable for the subject of H&M, given the fact that the subject is not a traditional subject.

European Capital of Culture 2015 - 2016
 DANCE Theater Company - 2015
 Hochschule Bonn

Mineral Layer Handout

Ray Mollerud
Kendallville Public Library, 2000
2000, 2001, 2002, 2003, 2004

It is a book — a must for all medical practitioners — is a really decent book in that it is a comprehensive legal volume for a first-aid solely for the second- and third-year. But it is a magnificent and pleasant fusion of both of these involving areas and I imagine the two sectors in balance between. Good choice!

Service News

Honours, Awards and Citations

Surgeon Commander T R Douglas RSCD CHC
Royal Navy
CBE

Surgeon Lieutenant Colonel Barker Royal Navy
DSC (Award)

Captain Philip OR Lee RNVR
Honoured as a Brother into the Order of St John

Clinical Excellence Awards

Surgeon Captain A J Whittall Royal Navy
J288 MOD Clinical Excellence Silver Award

Two years Captain M J Mawson Royal Navy
1058 MOD Clinical Excellence Bronze Award

Surgeon Captain A J Burgess Royal Navy
2935 MOD Clinical Excellence Award
Citation was for saving 8 grade D of myc on Award

Academic Achievements

Surgeon Commander D Blair Royal Navy
Distinguished in the MA in Defense Studies

Surgeon Commander N Eisenberg Royal Navy
MD

Lieutenant P Burnett Royal Navy
MSc with Distinction

PROMOTION

Surgeon Vice Admiral

Surgeon Rear Admiral P J Redfern CHC RSC
MR- MRCS- MRCP FFDR Royal Navy
currently Director General Strategic Change
He is Surgeon General in December 2008 - is
the rank of Surgeon-Vice Admiral - is
succeeding to Lieutenant General L P
Llewellyn MBE CHC

Surgeon Commander to Surgeon
Captain

Surgeon Commander P J Garton Royal Navy

Acting Surgeon Commander to
Surgeon Commander
Acting Surgeon Commander S ET McCulloch
Royal Navy

Surgeon Lieutenant Commander to
Surgeon Commander
Surgeon Lieutenant Commander G R Schofield
Royal Navy

Surgeon Lieutenant to Surgeon
Lieutenant Commander
Surgeon Lieutenant A L Coopers Royal Navy
Surgeon Lieutenant M J Sout Royal Navy
Surgeon Lieutenant J Repp Royal Navy

Acting Surgeon Lieutenant to Surgeon
Lieutenant
Acting Surgeon Lieutenant B Cristoforetti Royal
Navy
Acting Surgeon Lieutenant R Thomas Royal Navy

MEDICAL SERVICES

Lieutenant to Lieutenant Commander

Lieutenant P Burnett Royal Navy
Lieutenant E Duke Royal Navy
Lieutenant M G Vero Royal Navy

QARMS

Commander to Captain
Commander J M O'Connell QARMS

Lieutenant to Lieutenant Commander
Lieutenant S J Brodthurn QARMS
Lieutenant S D Brooke QARMS
Lieutenant R P Gorman QARMS
Lieutenant A O'Connell QARMS
Lieutenant S France QARMS
Lieutenant A Gunning QARMS



...the man on the left, wearing a patterned short-sleeved shirt, is smiling and looking towards the camera. The man on the right, wearing a white long-sleeved shirt with 'Castrol' and other logos, is looking down at a large, light-colored fish (possibly a shark) that is resting on the boat's surface. The background shows the interior of the boat with various equipment and a bright light source.

...the man on the right, wearing a white long-sleeved shirt with 'Castrol' and other logos, is looking down at a large, light-colored fish (possibly a shark) that is resting on the boat's surface. The background shows the interior of the boat with various equipment and a bright light source.

PRMC Gibraltar Team participate in Royal Navy Winter Sports Association (RNWSA) Championships

Legend

In January four members of the Gairdeid, four Phoenix Force men and a woman joined the British Forces Gibraltar, came to the island to help with the Royal Navy air strike against the Argentinian ships, and a helicopter pilot who went down between 1982-83 was in the Los Indios, France.

The seven sets of tests — repeated every 10 days up to a year and half — are the same as the tests administered during the 1990s. The only change is that the tests were challenged by "new" or "old" tests and with and without a year.

The purpose of the 1995 SA championships relative here to prepare players at competitive level for inter-club competition events and to develop players who had never

[illegible]

The senior manager, Lieutenant Commander Lorne England, informed business as usual in immediate coastal areas and north-westward. Commanders did not have to shift the boat out of its mooring during the event. A boat is deployed to the area and is in position.

Assistant Commander England District
 Strategic Team Manager



Military and Civilian Health Partnership Awards 2008



Left to right: Lt. Col. James J. Smith, Jr., Distinguished Award; Lt. Col. James J. Smith, Jr., Distinguished Award; Lt. Col. James J. Smith, Jr., Distinguished Award; Lt. Col. James J. Smith, Jr., Distinguished Award; Lt. Col. James J. Smith, Jr., Distinguished Award; Lt. Col. James J. Smith, Jr., Distinguished Award; Lt. Col. James J. Smith, Jr., Distinguished Award.

The 2008 Military and Civilian Health Partnership Awards ceremony was held at the National Defense Science and Engineering Graduate Fellowship Program, 1100 Wilson Road, Suite 100, Arlington, VA 22204. The ceremony was held on June 19, 2008.

The ceremony was held at the National Defense Science and Engineering Graduate Fellowship Program, 1100 Wilson Road, Suite 100, Arlington, VA 22204. The ceremony was held on June 19, 2008. The ceremony was held at the National Defense Science and Engineering Graduate Fellowship Program, 1100 Wilson Road, Suite 100, Arlington, VA 22204. The ceremony was held on June 19, 2008.

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Future Events

SpR Symposium

21 and 22 May 2009 contact Lieutenant
S Parker on 02392 765061

MDG(N) Symposium

15 and 16 September 2009 contact
Lieutenant G Barrett on 02392 765021

Blood Red Cocktail party and dinner

This is a very special year for the Royal Naval Medical Club. The Blood Red Cocktail party will be held on HMS MCQUEEN on Friday 26 June 2008 with the annual dinner at Greenwich on 11 September 2008. Tickets will be sent out in due course.

If you are interested in joining the Royal Naval Medical Club, you should contact Lieutenant Commander Halsey on the Secretary on 02392 825889.

Notice has been received of the death of the following:

Surgeon Vice Admiral T L Jenkins

Surgeon Rear Admiral D A Lammiman

Surgeon Commodore J W R Jackson Royal Navy

Surgeon Captain I A McWhirter Royal Navy

Surgeon Lieutenant Colonel P J Smith Royal Navy

Major General Sir J D Hall Royal Navy

His Majesty the King has caused any words in memory of them

Submit an original and two copies of the manuscript to the journal editor. The manuscript should be formatted in the following manner: Single spaced, on one side of the paper, double spaced between lines, 12-point font, 1-inch margins, and a cover page. The cover page should include the title, author's name, and affiliation. The title should be centered at the top of the page. The author's name and affiliation should be centered at the bottom of the page. The manuscript should be submitted in a hard copy and a digital copy (PDF or Word document).

Preparation of manuscripts

Manuscripts must be in English. It is the author's responsibility to ensure that the manuscript is formatted correctly. Manuscripts should be submitted in a hard copy and a digital copy (PDF or Word document). The manuscript should be formatted in the following manner: Single spaced, on one side of the paper, double spaced between lines, 12-point font, 1-inch margins, and a cover page. The cover page should include the title, author's name, and affiliation. The title should be centered at the top of the page. The author's name and affiliation should be centered at the bottom of the page. The manuscript should be submitted in a hard copy and a digital copy (PDF or Word document).

Title page

The title page should contain the title, author's name, and affiliation. The title should be centered at the top of the page. The author's name and affiliation should be centered at the bottom of the page.

Tables and illustrations

Tables and illustrations should be submitted in a hard copy and a digital copy (PDF or Word document). The tables and illustrations should be formatted in the following manner: Single spaced, on one side of the paper, double spaced between lines, 12-point font, 1-inch margins, and a cover page. The cover page should include the title, author's name, and affiliation. The title should be centered at the top of the page. The author's name and affiliation should be centered at the bottom of the page. The manuscript should be submitted in a hard copy and a digital copy (PDF or Word document).

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Manuscripts and illustrations

Manuscripts should be submitted in a hard copy and a digital copy (PDF or Word document). The manuscript should be formatted in the following manner: Single spaced, on one side of the paper, double spaced between lines, 12-point font, 1-inch margins, and a cover page. The cover page should include the title, author's name, and affiliation. The title should be centered at the top of the page. The author's name and affiliation should be centered at the bottom of the page. The manuscript should be submitted in a hard copy and a digital copy (PDF or Word document).

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Acknowledgements

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Member of the Association of Service Newspapers.



Figure 1.

history continued being positive. The patient stated that the lesions were not growing and were not itchy.

Clinical examination revealed numerous hyperpigmented lesions on the patient's face (Figure 1) and on her arms. The patient also reported a history of myoclonic jerks. Examination of the patient's hearing revealed bilateral asymmetric sensorineural hearing loss. The patient's hearing loss was diagnosed as bilateral high-frequency hearing loss and the patient given the hearing aid. The patient was asked to be alert to her hearing, to get her hearing aid, and then to review.

At the review appointment, the staff had agreed to make the patient's face, face, and conduct. No change in hearing or signs of symptoms were detectable. Through a medical and dental consultation, a dental diagnosis of hypodontia was made. The patient was reassured that the lesions were likely to resolve within several weeks and warned that there was a chance of recurrence.

The patient was not seen again on RFA, Mounts Bay but a letter to the patient by the MA on board RFA Lymington confirmed that the patient was healthy and the patient was asymptomatic.

Discussion

Dysphagia may have been a symptom of tuberous sclerosis.

The patient's history of dysphagia was likely to be related to the fact that the patient's diet was likely to be restricted. The patient's diet was likely to be restricted as being between 0.5 and 1 per cent. It is more frequent in cases that are related and tends to affect individuals of young adults, with 50 per cent of patients being under 20 years of age. The pathology is unclear, but the patient's diet is the most commonly identified trigger factor. The diet may be abnormal. A range of drugs, including oral contraceptives, oral hypoglycemic agents, oral contraceptives, and oral contraceptives, as well as alcohol, mycoplasma pneumoniae, and oral contraceptives have been associated with the condition.

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belong to a more severe disease spectrum. Long-term follow-up of patients with asymptomatic HIV infection is required to determine the true impact of this condition.

Patients with asymptomatic HIV infection are advised to have regular blood tests and have access to the following services: a) a local HIV clinic b) a local sexual health clinic c) a local drug and alcohol treatment service.

It is important to identify and manage the following conditions in patients with asymptomatic HIV infection: a) opportunistic infections b) HIV-associated lymphoma c) HIV-associated Kaposi's sarcoma d) HIV-associated haemophilia e) HIV-associated hepatitis f) HIV-associated renal impairment g) HIV-associated liver disease h) HIV-associated osteoporosis i) HIV-associated anaemia j) HIV-associated thrombocytopenia k) HIV-associated coagulopathy l) HIV-associated neuropathy m) HIV-associated myopathy n) HIV-associated cardiomyopathy o) HIV-associated angina pectoris p) HIV-associated coronary artery disease q) HIV-associated atherosclerosis r) HIV-associated stroke s) HIV-associated dementia t) HIV-associated depression u) HIV-associated anxiety v) HIV-associated psychosis w) HIV-associated schizophrenia x) HIV-associated bipolar disorder y) HIV-associated major depressive disorder z) HIV-associated manic depressive disorder.

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Conclusion

Asymptomatic HIV infection is an uncommon condition which presents with a range of signs and symptoms. It predominantly affects the young male population. Following the first blood test, a local HIV clinic will be contacted. Our case followed the clinical and laboratory findings of HIV infection and the treatment of the condition. However, the clinical and laboratory findings were not sufficient. Although this was the first time this condition had been seen clinically by the local HIV clinic, a management and care plan was developed for the patient.

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Plasma (HbA1c) is 8.0% increased. I took a 1000 mg dose of Metformin and after 4 weeks started to demonstrate some conflicting information on the internet as to how long to continue taking it. I do have a very good relationship with my doctor and he is very supportive. I have been taking it for 4 weeks and feel it is helping me to lose weight. I have been taking it for 4 weeks and feel it is helping me to lose weight. I have been taking it for 4 weeks and feel it is helping me to lose weight.

All terms except *deity* to Howard should be given as initial prophetic visit between March and November. *Prophet/Relator* (*Prophet* & *Chorus*) not as the standard term but, *Messiah* (*Prophet* & *Adapted*) and *Prophetic* the standard use. The *Prophet* as *Prophet* (not *Prophet*) in the text and not use for *Prophet* in the text.

Following the determination of the degrees of freedom (df) of an α priori approach to the data, this requesting can be stated as prophylactic planning either to have not used or to have used being issued. A significant result, which is likely not to have been detected, is given the test, H_0 and α level have been taking is returned for the parameter γ was less than α (e.g., $\alpha = 0.05$) and α level had been set at a significance α level risk of committing errors that would dominate the data.

An audit was designed with the aim of identifying PMs who were not given ASH (one to eight in theatre and 14 out of 1500 given prophylaxis into two venous catheters). This led to issues like lines of competence. The audit was in the form of a simple spreadsheet questionnaire. This was carried out in November 2006, co-ordinated with a survey

1. *Journal of Management Studies*, 1996, 33, 1, 1-14.

† *Abstracts from 2000-2001 and 2002-2003*
 are available.
 Yes/No

[illegible]

1000

At 1995 members of the 1994

Over half the respondents (51%) on the Commands list ruled out *business* as a potential cause.

He had been around Afghanistan since the start of the deployment but I remember I never had met

At least 10% of people have the same genetic mutation that causes Huntington's disease.

70% had been trying to lose weight for at least six months

Of the 16 not seeing Aids? I had never been tested before, even when in college. There's 10 years side effects on the (virus)? I stopped using there and or then recommended to her thought they all. Craig needed to take them, and had been told that there was no need to take them and that I'll cure a more other (then) so on a leave

Business given for each industry, RRP	number
New clients	18
Direct all services - released during trips	3
Not listed during	3
Not in general during trips	1
Other results	12

Over a quarter of the roads at the F&B were not using ADP in the course of the audit.

1. Please do not return items you intend to give away or sell.

...the most common cause of death in the ...
...the most common cause of death in the ...
...the most common cause of death in the ...
...the most common cause of death in the ...
...the most common cause of death in the ...
...the most common cause of death in the ...
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...the most common cause of death in the ...
...the most common cause of death in the ...

Audit Conclusions

Medical observation is still a good practice ...
medical practice is ... This audit ...
there are issues relating to such observation ...

...the most common cause of death in the ...
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	Chemological Prophylaxis
<ul style="list-style-type: none"> • Low-dose unfractionated heparin (UFH) • Heparin lock • Heparin lock • Intravenous parenteral compression stockings • 100 mg aspirin 	<ul style="list-style-type: none"> • Fondaparinux • Warfarin • Aspirin • Cytidine diphosphate • Subcutaneous heparin • Low molecular weight heparin (LMWH) • Venous thromboembolism

Table 2. Chemical and physical drug interventions of thromboprophylaxis

thromboprophylaxis is 2.3% (95) with a mortality rate of 0.5-1.0% (96-101). Deep vein thrombosis (DVT) is a common complication of lower limb surgery. Historically, the incidence has been quoted as 40-60% (95) but recent evidence has shown that this figure is much smaller. In a study in hip surgery 0.5-0.8% of total hip and total knee replacements (92-93). DVT associated with pulmonary embolism (PE) which occurs in 0.8% of total hip replacements (94-96) 1.1% and 0.1% of total knee replacements (94,97-98).

Pharmacological prophylaxis has been shown to be effective after the onset of DVT, PE and fatal PE (99) as well as being recommended for THA and TKA (100-102). The use of both mechanical and pharmacological methods was found to reduce the incidence of venous thromboembolism (see Table 3). Although research has shown a need to do more in the field of efficacy of such methods through more rigorous testing (103). In light of this, incidentally both the British Orthopaedic Association and New Zealand Orthopaedic Association suggest that this is the responsibility of the individual surgeon to determine the use of prophylaxis of thromboprophylaxis. It is most suitable for the present time. Though there have been several attempts to produce guidelines that prescribe pharmacological or the chemical methods of thromboprophylaxis directed to the patients, individual risk factors, these have been largely unsuccessful with some groups warning they can cause more harm than good (104).

Despite the evidence of individualised and universally accepted measures the vast majority of orthopaedic surgeons agree that the patients should receive some form of thromboprophylaxis. In 1992 only 32% of surgeons gave thromboprophylaxis to patients undergoing elective orthopaedics. In 1998 that figure had increased to 67% and now a decade later the number is likely to be much higher (105). In New Cross Hospital 84% of orthopaedic patients were prescribed thromboprophylaxis over an observed two year period in 2000.

It is widely accepted that patients undergoing orthopaedic surgery are at a greater risk of developing thromboembolic disease than those having general surgery (106). These are consequences of orthopaedic surgery and they contribute to venous stasis and therefore result in a increased risk of embolisation, including the venous position of the limb and the consequent responsibility to the blood vessels. Accordingly, patients need to be kept with prophylaxis be usually managed with an inflatable pneumatic to produce a bloodless limb.

Mechanical methods of prophylaxis are generally considered to be effective and without a significant side-effect profile (107). Their use is not recommended in patients with severe peripheral arterial disease (108). The efficacy of graduated compression stockings (GCS) varies from pneumatic compression and foot pumps has been shown to be equal (109). When used in those

[illegible]

Pharmaceutical and retail levels of generic drug sales have increased but have a significantly greater share of total sales than their branded counterparts. The share of sales that is captured by off-invoice discounts is of particular concern for the company. Drug manufacturers have taken the position of a limited number of off-invoice discounts, which is aligned with a generic drug. Consequently the off-invoice discounts and agents desire to not only be off-invoice but also to be

Research has shown that LM504 is more effective than metformin at decreasing the incidence of INTST-30. Although LM504 is a newer concern because of its safety (clinical trials that showed good results using LM504 indicate a higher rate of fecal incontinence), comparisons that include either metformin or LM504 are needed. Consistency in number of studies have been published that showed no differences in the rates of fecal incontinence compared between patients receiving LM504 and metformin (20). Despite the recent work has described LM504 as the gold-standard pharmacologic agent for the prevention of disease, its safety needs to be

biochemical methods of thermogravimetry can be safely used in correlation with photoacoustic spectroscopy. It has been demonstrated that a combination of both methods significantly decreases the risk of DDT but the effect on PLE has yet to be determined. It is generally considered that this multimodal approach is safer and contains less uncertainty [26, 28].

[illegible]

The 10-year study of 4,000 women equally at risk for the two types of endometrial cancer (hyperplastic and nonhyperplastic) shows that the efficacy of LAMN when started on a regular basis compared with oral progestins is equivalent in both women groups. It is thus the reduction of atypical hyperplastic area was not decreased in the hyperplastic group (LAMN is superior to placebo suggesting that it is effective and even safely a nonhormonal) It is likely that tamoxifen will fully appear the same effectiveness to decrease the overall risk of morbidity of hyperplastic endometrial dysplasia and that study will not have the same findings supporting treatment of the hyperplastic area, probably in the use of tamoxifen.

[illegible]

Only one state had fully voluntary reporting. New Mexico began collecting data on violence against children in November of 2000. The observations were collected by hospital emergency departments over four waves in April and May of 2000. In both instances all observations were made by consulting the medical and drug charts of all patients with head-injuries to their skull or face. It was noted whether or not the patients were using traditional methods of protection. Further information was obtained by discussions with the caregivers.

100

At Auckland City Hospital an estimated 1,000,000 mg of heavy metals is introduced to the waste stream.

The Role of NCMC and the UK Relationship

As part of the DSA, NCMC produces 15 vital all-source medical intelligence assessments of threats and capabilities of foreign military and coast/army health care capabilities and health services for threat assessment, force, combat and humanitarian health issues, and the ability to fight and life support issues. The NCMC is a methodology and nuclear biological and chemical defence education.

NCMC is the only organisation in the world with the comprehensive medical intelligence function. As such, it has a better customer base, from operational and tactical commanders, progressive medical personnel and medical planners and commanders in the military, defence and other federal agencies. Force Protection forms the base line of NCMC products and is integrated to provide immediate and unique, valuable force protection measures and data for use in early stages. Examples of these products are the assessment of enemy's health care capability of threat, where we may, respond or may deploy CBR or chemical threats, we also provide assessments and analysis of any chemical agents including chemical agents and medical capabilities of foreign nations, to help inform possible levels of threat, support.

The four main nations (USA, UK, Canada and Australia) share and collaborate on medical intelligence issues and have established the Quadripartite Medical Intelligence Centre (see there is a rotating Chair among the four nations with Canada currently holding that position). The UK works and liaises up to closely with the US in exchanging threat intelligence and producing all source assessments so that US, UK and Canada, in the interest of intelligence requests for information, etc.

It is at the conference coordinated areas for most recent events where the UK and US have collaborated, present our views on the NATO outcomes. Although NCMC took the lead and collected much of the unclassified intelligence, available, spot and vital, it was provided by Canada, Australia and the United Kingdom. The UK spot was

provided collect only from DMO, PIRG and the Joint Project on Agency, a good example. I think of how collaboration works not only at the international level but also within the UK itself. An internal amount of work has been put into this, was not only to ensure that, most of the have an deployed position forces but also the capability of world health care systems to be able to both work and perform the work.

The UK has a relatively small Medical Intelligence organisation and benefits greatly from the relationship with NCMC. NCMC has a large amount of resources available to it and where able to do so will readily share the information and do some work us. The relationship is not completely one sided as we run the UK, the provide a lot of talent and level head, into the system, but there is with NCMC a comprehensive all source approach.

NCMC has recently gone through a role change, this has led to the Armed Forces Medical Intelligence Centre (AFMIC) as well as in the UK supplies to provide medical intelligence to the UK armed forces. NCMC's designation as a national centre, where the growth of its roles and responsibilities has started to be under way for several years. The growth has included expanded relationships, beyond the UK, Department of Defense and the US intelligence Community. The first instance of this has occurred in the form of visits where the intelligence assessment provided by NCMC brought valuable planning and was in this space, to the US authorities well before the PIRG announced its pandemic HR 95.

The UK Integrated Officer Role

Before taking up this appointment, I undertook a number of PFT courses including the NATO Medical Intelligence Course and a number of Defence Intelligence courses in various UK locations. All have proved to be extremely useful and, down to my due to here and enabled me to get involved in education and production quite early on into my tour. I have also been fortunate enough to be able attend a number of US intelligence courses covering critical thinking and advanced analysis techniques.

As an IOI, one's primary task is to share the US system and our rich "need-to-know" information for assignments in the UK. However, there are plenty of opportunities to produce individual work both as a co-author and as the lead analyst. Here at NCMI, production is across the full range of NCMI products from briefs for force protection type reports and analyses to in-depth work providing real-time intelligence on developing events. During a 2 year tour at NCMI we rotate through each of the divisions gaining an insight in to their reporting, thinking and production techniques. Each division is a

discipline and it is surprising how much of our own background we are bringing to a new set of work even if it is not a totally foreign discipline. Our broad range of experience as Naval Medical Service Officers provides us with the a posting such as this. It allows us to both contribute the experience and knowledge acquired from our previous deployment for Medical Intelligence Capability in the UK and add an important "top-down" view into the US, for what is by and large their investment, by being able to contribute to the intelligence products within the reporting NCMI.

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General

Writing your postgraduate dissertation: a basic framework

S Walker

Abstract

This paper provides a brief framework for those embarking upon a postgraduate dissertation. The structure is divided into eight main components: the title and abstract, development of the research question, literature review, methodology, data collection, analysis and interpretation, conclusions and recommendations, and the final chapter. A good dissertation is the result of a sound understanding of the research question, a clear and concise statement of the research objectives, a well-defined methodology, a well-defined data collection, a well-defined analysis and interpretation, a well-defined conclusions and recommendations, and a well-defined final chapter.

Introduction

The purpose of this paper is to provide a brief framework for those embarking upon a postgraduate dissertation. The structure is divided into eight main components: the title and abstract, development of the research question, literature review, methodology, data collection, analysis and interpretation, conclusions and recommendations, and the final chapter.

The first component of the dissertation is the title and abstract. The title should be clear and concise, and the abstract should provide a brief summary of the research question, methodology, data collection, analysis and interpretation, conclusions and recommendations, and the final chapter. The second component is the development of the research question. This should be a clear and concise statement of the research question, and it should be supported by a literature review. The third component is the literature review. This should be a clear and concise statement of the research question, and it should be supported by a literature review. The fourth component is the methodology. This should be a clear and concise statement of the research question, and it should be supported by a literature review. The fifth component is the data collection. This should be a clear and concise statement of the research question, and it should be supported by a literature review. The sixth component is the analysis and interpretation. This should be a clear and concise statement of the research question, and it should be supported by a literature review. The seventh component is the conclusions and recommendations. This should be a clear and concise statement of the research question, and it should be supported by a literature review. The eighth component is the final chapter. This should be a clear and concise statement of the research question, and it should be supported by a literature review.

The purpose of this paper is to provide a brief framework for those embarking upon a postgraduate dissertation. The structure is divided into eight main components: the title and abstract, development of the research question, literature review, methodology, data collection, analysis and interpretation, conclusions and recommendations, and the final chapter.

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The Dissertation Framework

The dissertation framework is a clear and concise statement of the research question, methodology, data collection, analysis and interpretation, conclusions and recommendations, and the final chapter. The framework is divided into eight main components: the title and abstract, development of the research question, literature review, methodology, data collection, analysis and interpretation, conclusions and recommendations, and the final chapter. The first component is the title and abstract. The title should be clear and concise, and the abstract should provide a brief summary of the research question, methodology, data collection, analysis and interpretation, conclusions and recommendations, and the final chapter. The second component is the development of the research question. This should be a clear and concise statement of the research question, and it should be supported by a literature review. The third component is the literature review. This should be a clear and concise statement of the research question, and it should be supported by a literature review. The fourth component is the methodology. This should be a clear and concise statement of the research question, and it should be supported by a literature review. The fifth component is the data collection. This should be a clear and concise statement of the research question, and it should be supported by a literature review. The sixth component is the analysis and interpretation. This should be a clear and concise statement of the research question, and it should be supported by a literature review. The seventh component is the conclusions and recommendations. This should be a clear and concise statement of the research question, and it should be supported by a literature review. The eighth component is the final chapter. This should be a clear and concise statement of the research question, and it should be supported by a literature review.

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provides the basic structure for your research so it is essential that it is well considered at an early stage with an appropriate mix of qualitative and quantitative approaches. Methodology therefore forms the foundation on which the data is then a description is gathered and analysed.

Qualitative research involves the collection and analysis of human data from studies that may take one of a number of designs. The most rigorous form of research is the randomised controlled trial in which a randomly selected group receive the study intervention and a further group receives the standard intervention, a placebo. Systematic reviews are studies in which are to combine the studies from many randomised controlled trials. In order to obtain a more precise understanding of treatment outcomes. Quantitative approaches have been widely widely referred to as the gold standard for medicine because of the scientific basis of clinical practice. However, in recent years qualitative approaches have been recognised as having a role in providing us with a greater understanding of the patient's experience and the human nature of medicine. Quantitative and qualitative approaches are now increasingly being viewed as complementary clinical trials are always be based on quantitative methodology so as to ensure the clinical outcome of patients is relevant.

Qualitative research aims to adopt a holistic or all round perspective to understand the complex nature of human behaviour and interactions. Interviews, questionnaires and observations are the main methods of the qualitative toolkit. The qualitative approach can best be described as a philosophical method of enquiry with the subject way that researchers view of their conclusions. A qualitative researcher uses personal life experiences with his or her research subject (the way in which he or she processes and interprets knowledge. The way in which knowledge that has been gathered through the qualitative research is, ultimately, called an interpretive paradigm. Some qualitative researchers have attempted to adopt a more rigorous and scientific approach called postivism to guard against the

bias that always the weakness of human beings to bias and prejudice of knowledge. The use of several different methods and approaches during the research process is called triangulation.

The majority of medical and surgical interventions will contain a research no study service with some comparing the main themes of quantitative and qualitative approaches.

Research Tools

When one has selected the chosen methods of enquiry to the next step is to develop tools to go out into the field and collect some data. A questionnaire is one sort of open and closed questions, although it is better to focus to have a mixture of both so as to gain the opportunity to explore freedom in answering their views. An interview schedule, which is the end of a questionnaire provides respondents with the freedom to add anything that is relevant. Before the research tool is used to test it out it is important to conduct a pilot with colleagues or some local volunteers in order, a good way to select a few respondents in the field is to identify the questions and respond to a general sense. Constructive feedback obtained during the pilot stage can inform the research about flaws in the design of the research tool and adjustments can be made at the pilot stage that preserve the integrity of the research.

Questionnaires and interviews should follow a logical pattern. It is important that those participating can see the logical flow of where the research is going. People who are busy are unlikely to be inclined to give up time to complete a questionnaire if it is badly organised and if they can't easily understand the purpose of the research.

Using a questionnaire means one can reach a real or post the questionnaire to respondents. If post is chosen then it is always a good idea to include a stamped addressed envelope that actually have been more willing to complete and return questionnaire where the researcher has been prepared to spend the time writing to them individually. However, an increasingly popular method is to put on of the many

online a general framework of information to inform our limited knowledge of the major learning difficulties, making the communication of information much easier to appear to show information gathered and critical appraisal is a real one that involves the two main stages of the process of making the issue of methodology to be used. Information

Conclusion

Using a research framework is a very early learning experience. It is an early learning experience for the first time, and it is a very early learning experience. It is a very early learning experience. It is a very early learning experience.

and objectives are defined at the start of the project, the process should be entirely transparent. The methodological framework provides the basis on which the research process is structured and governed throughout. Making best use of university officials and Library Services is a good idea to deal with the data before the data is performed. Making best use of the data is a good idea to deal with the data. The conclusion drawn from a research project often provides the best way to deal with the data. The conclusion drawn from a research project often provides the best way to deal with the data. The conclusion drawn from a research project often provides the best way to deal with the data.

*Professor Richard Thomas, MRC Clinical Trials Unit,
University College London, UK*

General

New Entry Medical Officers Course 2008 – a personal review

Jonathan Evans



One thing I have learnt by talking to a few experienced and seasoned Medical Officers is that everyone has been through different medical education and/or training prior to the general duty course, or deep course. I have put together this personal account of the 2008-09 NEMO course. I apologise to anyone I have left out, possibly misinterpreted or have stolen things from.

During some Royal Navy days in the future again 2 years working in a Ministry. Decided on my Foundation Programme (after 10 years in the Royal Navy) and I entered the Royal Navy on 28 August 2008 for my New

Entry Medical Officers (NEMO) course. The course was made up of 26 people. 4 of us had some naval medical training and the rest were going to become anything but a doctor.

The first few days consisted of a large amount of paperwork and getting to know each other. Not doing a thing. I stayed by POOT (Port of Operations) and was never allowed to go out of the ship.

The first couple of weeks were spent in the ship, but then we moved to the shore. I had a lot of time to spend, staying at the shore. I was quite busy for a while, but then I was unprepared for the ship. I was not a doctor.

we got to know the RAF at 11 years in more depth, much a nod by the sea side of the water gun room bar. As it came to passing out we showed the *Wendell* it is looking at the medical officers are recruited for, as well as going into although we understood the physiology behind landing on paratro, we were unable to keep it happening to ourselves. Overall we all hope we showed ourselves in a good light at BAFAC but we as did many enjoyed ourselves for more than we ever imagined. I certainly hope to have much more to do with many of the people we came to be friends with during our time at the college both staff and cadets.

The New Year brought us back to Fort Blockhouse to see that everyone had put the weight they lost at BAFAC back on. In order to complete our weapon handling course and RAHFT. The money of two doctors becoming medics was only overshadowed by the one HMO who was unable to shoot straight enough even to aim their S&B0 inadequately enough to start to aim the laser. The second half of the year took us to Fleet Headquarters where we were introduced to much of the paperwork and support systems we would soon be exposed to as well as a chance to meet many of our seniors.

Our trip to RFF Review for our senior medical module was not as we expected the underwater medicine backwards. It was however a fascinating subject with many of us leaving thinking we may well put it in practice under to become first aid pilots. We had the opportunity to land planes in flight simulators for again round back than any human should be in the experience of psychology and again under hypoxia in the drop-out jump tank where we found that wearing orthopaedic actually became able to copy simple shapes when hypoxia when they can't see but still breathing normal air. We were very grateful to the RAF for looking up in an interest to well run and extending help although under one angle it was not to look a Royal Navy Surgeon and CPO.

Upon going into smaller groups for our

week long clinical placement I was off to HMS CPOAC to see everything we had heard over the last few months, in great no. The chance to see all the services that are available and how a life in it was available. The highlight of the week was undoubtedly the chance to go onboard a ship with HMS as it reached the end of its sea trial in Plymouth based in the Royal Navy for nearly 40 years it was the first time I had set foot on a real ship (never mind been at sea). I was later informed however that not only was I not eligible for a medal by not being Plymouth based but I hadn't even qualified for my LSA! I must say a personal thank you to all involved in one of the best weeks of my M&M2 course in particular CMA Smith who ran the course for us and Surgeon Captain Connors who took us out on a FCSF visit with him.

Our Divisional Officers course at HMS COLLEGEWOOD was certainly an eye opener to the real world of the Royal Navy. We went through the 2 week course with many other CPOs who'd either been to tell us how things actually happened and fit in this gap that were so neatly left out of our time at BAFAC. One particular highlight was the lecture on experience and awareness that led to a visit to JPR and many retrospective deaths.

As we all departed into the fleet we had a chance for a final farewell meal a most bit of time for the year, signing speeches and photo montages of our own.

So now we are no longer M&M2s but OD&M2s at the back end of the experience and about to embark on what we have been assured is the best phase of our Royal careers so if you come across us, you now have an idea of what we have been taught but please whatever you do handle us with great care.

Finally, on behalf of all the M&M2s, I would like to thank everyone involved in all aspects of our course. In particular Lt Surgeon Captain who had to put up with many whinging trainees as go through could have prepared for us, as well as all the staff in the right place at the right time and indeed we had a highly capable but more importantly highly enjoyable course.

General Defence Audiology Services

G Duffy

The Defence Audiology Service (DAS) is staffed based in 1941 Marine, allocated to the Maritime and Naval Medical Supporting Officer (MNSO).

The service is a four and a half shift of three staff. There are stages to test and screen off duty. We have two full time staff (audiologist, screen and a valid range of equipment for personal hearing and otology in 1941).

There are staff in the department to provide a hearing aid service along with the screening personnel. This is an 1941 screening staff who are on duty for the day and night. There are also staff on duty for the day and night.

The staff provide a hearing aid service to all personnel. We are also able to provide a hearing aid service.

We are able to provide a hearing aid service to all personnel. We are also able to provide a hearing aid service.

We are able to provide a hearing aid service to all personnel. We are also able to provide a hearing aid service.

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We are able to provide a hearing aid service to all personnel. We are also able to provide a hearing aid service.

We are able to provide a hearing aid service to all personnel. We are also able to provide a hearing aid service.

History

Candidates for medical commissions in the Royal Navy, exam results 1865; some things change?

J V S Winkenden

The Medical Council. *British Medical Journal* v. 1 no 282 (May 24, 1865) pp. 544-555

Medical Service of the Navy. The RESULTS of the following communications from the Director General of the Medical Department of the Navy with reference to the examinations of candidates

Addressed M.C. 27th February 1866

Sir With reference to your letter of the 27th of May 1865 I have the honour to forward for the information of the General Council of Medical Education and Registration of the United Kingdom a Report from the Director General of the Medical Department of the Navy with reference to the examinations of candidates for medical commissions in the Royal Navy during the year 1865

I have the honour to do so for your very obedient servant
A. BRITTON Director General

Dr F Hawkins, Registrar of the General Council of Medical Education and Registration of the United Kingdom 33, Southampton Row

Addressed Somerset House 18th Feb. 1866

Sir

I have the honour to acquaint you for the information of the General Council of Medical Education and Registration of the

United Kingdom that during the year 1865 177 persons candidates presented themselves for examination for commissions as assistant surgeons in the Royal Navy

- Of these 177 had been previously qualified and assisted and one underwent two examinations only during the previous morning as he had been unsuccessful on the first occasion
- Of the total number of candidates who presented themselves twelve were 'unsuccessful and were admitted into the Majesty's service and one has not as yet satisfied us as to the progress of his qualification being completed
- Of the twelve successful candidates five possessed a good command of the English language and were natives, one possessed a good command and five not beyond reasonable limits
- Of the five candidates who were not previously qualified good examinations on the second occasion and three were again rejected
- The majority of these rejected were either ignorant of the Latin language two third altogether in Anatomy and Surgery and two were ignorant of *Medicæ Medicinæ* (that it would have been dangerous to have granted them as qualified) (1865W) 1-1
- In considering our impressions of regard to the proficiency of the Latin language should be it observed for a large number of the candidates who failed themselves for

Service News

Honours, Awards and Citations

Surgeon Rear Admiral P J Pollard (CMB 304 MB, MRCS, MRCP, FRCR)
Royal Navy Fellow of the Royal College of Physicians of England

Surgeon Captain (SB) G E Scott Royal Navy
Robert-Elli Memorial Prize 2008 (Academic) (Fellow RCDs)

Surgeon Commander J Reed Royal Navy
Fellow of the European Medical Association

Surgeon Lieutenant L Herbert Royal Navy
Member of the Order of the British Empire

Asstt Chief Petty Officer (Medical Assistant) V Taylor
Order of St John

PROMOTION

Surgeon Captain to Surgeon Commodore

Surgeon Captain C J G McIntire Royal Navy

Surgeon Lieutenant Commander to Surgeon Commander

Surgeon Lieutenant Commander K Houborg Royal Navy

QAIMS

Chief Petty Officer to Warrant Officer

Chief Petty Officer Royal Naval School Epsom

PLACED ON RETIREMENT

EMERGENCY LISTS

Surgeon Commodore T Douglas Pile Royal Navy

Surgeon Captain M A Morgan Royal Navy

12 March - PRMC nursing staffs celebrate International Nurses Day and the birth of Florence Nightingale

L. England, J Hill

THE PRINCESS ROYAL MEDICAL CENTRE GIBRALTAR



FLORENCE NIGHTINGALE SERVICE *Service celebrating the nursing profession* Thursday 12 May 2009 at 1130

I do not believe that nursing is a thing which will be any one making progress with in a 12 month every 12 will take up word for a year and going back.

Florence Nightingale

Princess Royal Medical Centre Celebrates International Nurses Day 2009



Each year, on the 12th May, the day on which Florence Nightingale laid down a service, is held at Westminster Abbey, London, to commemorate her life and to recognise nursing as a profession. Out of the very first PRMC Nurses from the Nurses' Chapel will be invited to sit in the Gallery and headed from the nurse to the desk. The first nurse will be invited to sit in the Chapel with their place to sit in the High Area. It is a special day for Florence is understood to reflect.

Aspirin was first used as a painkiller in 1853. It was developed by a German chemist, Felix Hoffmann, who was working for Bayer. Aspirin was first used to treat rheumatism, but it was later found to be effective for a wide range of conditions, including heart disease, fever, and pain. Aspirin was first used in the form of a tablet, but it was later found that it was more effective when taken in the form of a powder.

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In 1853, Felix Hoffmann, a German chemist, developed the first synthetic aspirin. It was a major breakthrough in the history of medicine, as it was the first time that a drug had been synthesized in a laboratory.

The first use of aspirin was in 1853, when it was used to treat rheumatism. It was later found to be effective for a wide range of conditions, including heart disease, fever, and pain. Aspirin was first used in the form of a tablet, but it was later found that it was more effective when taken in the form of a powder. Aspirin was first used in the form of a tablet, but it was later found that it was more effective when taken in the form of a powder.

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Future Events

SpR Symposium 2010

17 and 18 June 2010 in central London
Membership at £2300/1800*

NOG/Deafness Research UK Operational Noise Induced Hearing Loss Symposium

24 November 2009

Contact: L. Aitkenhead-Nicholson on 020307 78800*

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In order to increase awareness of our sister Journal, it has been agreed that we will each publish the respective contents pages.

Journal of the Royal Army Medical Corps

Volume 154 No 4

December 2008

Original Papers

Which Outfit and Directorate Frameworks (QOF) clinical indicators are applicable for British Forces Germany Health Service (BFG HS) primary care?
M G J van den Heuvel, R D Sijpeste

Analysis of the clinical services of command and control arrangements for medical evacuation of seriously ill or injured casualties in Southern Afghanistan 2007

R J Corbett, M B Cooney, D Ryan

Operational Myeloma - The Desert Cross 1968

P J Parker, N Kirby

Performance indicators for prehospital command and control developed for civilian use tested in a military training setting - a pilot study

C Lundberg, A Jonsson, T Wikstrom, A Runo

The use of improvised bullet markers with 3D CT reconstruction in the evaluation of penetrating trauma

A Renucci, D B Hootley, A J Brooks

Case Reports

Juvenile lymphogranoma presenting as an ovarian mass

R Noma, M Dwyer, R S Renshaw, R L Cheung

Phycothododermatitis after gardening

G Wood

Brief Assessments

Orthopaedics & Trauma 5

M G P Bentley, P R J Page, A Doozgatseri, P J Parker

Medical Victoria Crosses

A Colenso-Victoria Cross: The Award to Major William Bates
P H Searcy

Meetings & Abstracts

Event in TRIPLE (SEPTEMBER 2008)

A McCourt, J Peadar, J Lusk

FeldTrauma Care in the 21st Century

D O'Reilly, T Koenig, M Re

Career Focus

Public Health Medicine in the Defence Medical Services

D A Ross, P L Pudney, A H McG Macdonald

[illegible]

Notice has been received of the death of the following:

Surgeon Captain Dr P.C. Lindsay-Rose FRCS

Lieutenant-Commander J.R.F. Lane RNVR Navy

Lieutenant-Commander P.J. Macdonald RNVR Navy

Commander B. Good LCDR

Major G. Marshall J. Honorary

The editor would welcome any words of condolence if these

Administration Notices

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Tables and figures should be prepared in the paper unless they are prepared in the text. Each table and figure should be on an individual page separate from the text. The manuscript should be prepared in the text and have an explanatory note on the page where the table or figure is referred to.

Tables, photographs of scientific material, and other material should be prepared in the paper unless they are prepared in the text.

Manuscripts should be prepared in the paper unless they are prepared in the text. Manuscripts should be prepared in the paper unless they are prepared in the text.

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Measurements and abbreviations

Measurements should be given in the units in which they were made but with the exception of blood pressure, viscosity and haemoglobin concentration in g/dl. All metric units must be accompanied by their SI equivalents. The accepted name of drugs should be used. Proper names may follow in parentheses. If an abbreviation is given, the term for which it stands should be given in full at its first mention in the text, e.g. the rate of flow (ml/min) (RFR).

References

Responsibility for the accuracy and completeness of references lies with the author and these will not be checked by editorial staff. Only essential references should be included and authors should verify these against the original documents. References are identified in the text by superscripted numbers and are numbered and listed consecutively at the end of the manuscript in the order in which they are first cited in the text. A full list of references should be given at the end of the paper using the form of reference adopted by Jones and Jones. Papers accepted but not yet published should be included in the references followed by 'in press'. Those in preparation (including any submitted for publication) personal communications and unpublished observations should be referred to as such in the text only.

Acknowledgements

The author(s) of those who are not authors but made substantial contributions to the work should be acknowledged as should the receipt of grant support, equipment, drugs, facilities etc.

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ISSN 0022-2966

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approach is to use www.fishbase.org under Osteichthyes: Marine Group: teleostei: (fishes) and then the division is strong wales in the Centre: (can be 1 click)

I hope you enjoy this website. In addition, I will send healthy crop of papers well before it is available. We should figure out how to get some papers and I have enjoyed reading them. Please send me some papers. I agree with your general sense. Many discussions remain as open (interesting) and all. Any? I am sure that is full up of your success. If we probably better.

David Brown

Clinical vignette: Urinary ICU

CU is a plant oil extracted from seeds (Fig 1).¹ The proprietary name call digested oil of the Indian seashore sea anemone, *Metridium*.² This is an anemone which along the coastline of the port area with anaphylactic reactions.

- The above prevalence has data for general population
- More common in males aged 10 - 35
- Rapid onset of rash and pruritus within minutes of contact
- Symptoms usually last < 120 mins
- Treatment is the most common cause

Singh J, Lawrence S. J. Anemone Plant

- Severe symptomatology can include fainting, abdominal cramping, diarrhoea, nausea and vomiting
- Hypotension, injury, angioedema, asthma and even anaphylactic reactions are also reported
- Treatment is by avoidance and/or antihistamines or corticosteroids
- Pot and potassium is avoided

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1. International and medicinal standards (1995) 10, 1000-1000. Baker & Schwartz. MD. 1000
2. Kumar & Chatterjee. *Journal of the Royal Naval Medical Service* 2005; 161: 125-3

Clinical

Morbidity rates on Vanguard Class submarines during nuclear deterrent patrol: a retrospective review over 13 years

M K O'Shea, M J Scott

Abstract

The submarine responsible for the United Kingdom's nuclear deterrent have caused a particular factor in their medical care, since the programme is closed. The Vanguard Class of submarine carries approximately 150 men and doctors for about 3 months at a time. One of the central issues of submarine operations, is a remote and isolated and so such the submarine will only surface in an emergency which may include the occurrence of casualties. The prime reason for the use of a medical officer is to manage any medical or surgical outcome, however for medical reasons.

We summarise the medical section of the patrol reports submitted upon completion of each patrol over a 13 year period to determine both the rates of medical and dental attendance onboard and also the occurrence of potential medical threats to patrol integrity.

The most common reasons for attendance were dermatological and musculoskeletal consistent with previous studies of this population and working environment. There were few dental cases due to the high rates of dental fitness in the generaling crew. Patrol threatening cases occurred at a rate of approximately 1 per 3 patrols, with acute appendicitis being the most common presentation. The progressed to evacuation at a rate of 1 per 15 patrols, with the successful onboard management in 78% of cases.

The great danger onboard has limited room for equipment and commonly no surgical suite present, basic surgical equipment and no opportunity to seek senior advice and a

therefore relies on clinical judgement. Despite the limitations placed on the doctor onboard these submarines they have generally been able to reduce the rate of medical evacuation.

Introduction

The deployment in 1995 of the British on Class SSBN Ship Submersible Ballistic Nuclear submarine has marked the beginning of the United Kingdom's opportunity of sea nuclear deterrence, with at least one submarine always on station ready to deploy her missiles. These have subsequently been replaced with a fleet of four Vanguard Class SSBNs, which currently provide the UK's independent strategic nuclear deterrent.

HMS Vanguard, the first of class, was commissioned into service in 1993 and has since been joined by HMS Vengeance, HMS Vigilant and HMS Vengeance. These submarines carry the 7 pose, 3 DG ballistics missile warhead and are the largest of any war built, the exception of the United States and Russian Polaris. Their design deployment is approxmately 18 000 km² and with crew a complement of approxmately 150 men. The prime fuel and supply is an optimal, fully enclosed and constant ventilation and of to a regulated atmosphere for prolonged periods. An SSBN on patrol may remain submerged for a maximum of 3 months and endurance is only limited by the logistical aspects of carrying and storing a stock.

Fundamental to the provision of the capability of sea nuclear deterrence is the

detected by the (no constraints) in a semi-undisturbed surface (eg ground). The magnitude of the divided (ie current) or undivided (ie total) on the surface will be affected by factors related to the measurement conditions eg the period, unless filtered to by an atmosphere. Such measurements may include the concentration of molecules of the ship's Company for medical reasons.

To measure age for the rest, outdoor tests are a relatively young, healthy population of adult males who undergo rigorous medical assessment to determine their suitability and command suitability for the submarine service. In addition, in order to ensure the potential need to break patrol for medical reasons, a doctor is the form of a submarine qualified Medical Officer (MO) has been there on every deterrent patrol since inception. The practice of the Royal College of A for a 111 to be the 100% of the French and Royal Navy. This is due to the deployment of multiple MOs by other countries so that they may compromise the position of a single unit during an evaluation of MOs comprising the strategic element.

Royal Navy MOs are General Quarters Medical Officers, having completed their medical education in England and then undergone postgraduate education, but not having achieved higher professionalisation. Prior to joining the Royal Navy, each MO will undergo an entry and subsequently a further 12 months of training. The latter consists of a four-month subsea course including exposure to a wide range of training principles, submarine operations and medical physics, to the more in-depth applicable topics of medicine, protection and atmosphere control.

Deployment on a MOs presents a wide range of unique doctors' working in an isolated environment where medical personnel, equipment and equipment are limited. In addition, the current nature of a deterrent patrol demands that no communication is transmitted from the submarine, except in the event of an emergency, and therefore no use of medical advice may be sought by a MOs on patrol. While there have been several recent studies concerning the health at sea of

submarine crews, to date the most notably the USN there have been no such reports relating to the Royal Navy for almost 20 years (1).

In this study we did not attempt to assess the nature of medical consultations occurring at sea on Vanguard Class nuclear deterrent patrols, and the impact of significant rates on these patrols.

Methods

On completion of each deterrent patrol, a comprehensive patrol report is submitted to a variety of key departments, for analysis included in this study is a medical section completed by the submarine's MOs. During medical atmosphere control and health physics matters occur during the patrol the medical section is supervised by the Deputy Principal Medical Officer (diagnostic head of MOs) Neptune, as part of the post patrol report process and to provide a resource for clinical governance. This document provides a standardised summary on about 100 number and nature of medical consultations made on sea and describes, in greater detail the significant cases.

A retrospective analysis of the medical sections of patrol reports from Vanguard Class deterrent patrols covering the periods 1994 to 2000 was conducted. In addition to the analysis of total patrol statistics, the data was subsequently divided into the following two groups of sub-analysis:

- 1) Areas of medical surveillance
Consultations were divided into the following 10 major groups: Cardiorespiratory, Dermatology, Ear, Nose and Throat, Gastroenterology, Genitourinary, Neurological, Ophthalmological, Musculoskeletal including soft tissue, musculoskeletal, Respiratory, Surgical (including all soft-tissue injury), Trauma and Other. This gave the number of cases for each patrol which were then added to give a total incidence for all patrols.

The number of personnel embarked was plotted on by patrol duration to give the number of man-days for which the population had been at sea. This was then applied to the incidence to give incidence rates for each

dentist group. Their work sheet expressed as both per 100 000 man days and per patrol.

2) Dental treatment of rates of dental attendance

A dental (dentist) section was assigned to dental personnel on a 7 day basis using the groups 1001, 1002 and 1003. This division on the Order for attendance was made at the dental branch reported on daily. This is based on the Defence Order for 100000 man days of each submarine during the number of personnel in data for nuclear deterrent with to sustain up dental treatment required. All Royal Navy Medical Officers were on duty on the first management of dental problems that they present at sea. However, the training is designed to effect temporary solutions, to not give up at such time as the patient can be returned to the DSD for definitive treatment.

3) Impact of dental shortening cases

A case was considered a short to period if it affected any of the following items:

- The DSDM noted it as a short to the period in its report.
- The report noted that the submarine's Command had been involved in the case.
- The case was referred to them to help help or assist.
- The case required surgery under anaesthesia whilst at sea.
- Unusually high evacuation was required.

Results

A total of 24 DSDM patrols were conducted over a 12 year period between December 1994 and February 2008. The total patrol duration was 4000 days of sea with a mean patrol

duration of 89 days (range of 14-102 days).

Of these patrol reports, 85-88% gave the number of Suits on board (SOB) with a mean of 142 men per patrol (range 105-160 men). The number of man days for the relevant 9 patrols was calculated using the standard Scheme of Complement (142 men) and was included in the calculation of incidence rates for both medical and dental attendance.

The number of SOB was multiplied by the relevant patrol length in days to give an exposure in man-days per patrol. The patrol frequencies for each patrol involved in the analysis were added to give a total exposure.

3) Rates of medical attendance

The medical data from the 26 patrol reports were analysed. Of these, only 26 (47%) contained sufficient information to allow the calculation of incidence rates by attendance type. Incidence rates were calculated from a total exposure of 262 176 man-days. The results are shown in Table 1.

3) Dental attendance rates of dental attendance

Dental fitness was noted in 23 patrol reports. The mean reported dental fitness was 82% (range 56-100%). It is of note that the DSDM report covers only the Ship's Company. Additional personnel (aircraft for a patrol) is a separate item other units are not included in the report.

The dental data from the 26 patrol reports were analysed. Of these, 84 (85%) noted the total number of patients seen by dental services allowing a total incidence rate to be calculated from an exposure of 688 871 man-days. The total dental incidence was across these reports was 2000 cases per 100 000 man days.

Sex	DVS	On 10	1001	On	1002	Results
1001man days	4.44	144.2	26.52	14.44	22.78	8.25
Female	0.46	1.52	6.14	1.25	2.48	1.61
Sex	Age	1001	Female	Age	1002	Age
1001man days	20.50	114.88	17.26	14.44	14.44	84.2
Female	2.77	0.84	1.26	1.87	0.88	0.71

Table 1. Rates of medical attendance for 26 patrols by age/sex group (688 176 man-days).

Pre patrol cases	Post patrol cases
Control status of Overline (L2) Firewater Spw/gow pressure Suspension test water tunnel	Shoreline observation

Table 3. Type and number of a prepatrol case and post patrol cases

casualty evacuation from the submarine, water gas trial or to conducting or just follow up completion of the patrol and therefore were not patrol threatening events per se (Table 3).

Observations

The objectives of the study were to determine both the work rates of medical and dental attendants during different patrols and also to assess the challenges faced by the junior doctors providing the sick medical care (support and relief report) and the personnel duties preserving the integrity of the patrol by ensuring the non-leakage of members of the crew for medical reasons.

Data collection

A total of almost 5000 data were spent at sea over the 24 patrols studied. With each submarine carrying an average of 150 crew and a typical patrol lasting approximately 30 hours, all within a submarine, completely self-sufficient and continuously hazardous environment. There is considerable potential for illness to occur as a result of primary pathology or secondary accidents or injury.

Critical tasks upon the patrol include reports, sea (or non-standardised) and highly variable regarding format, employed by successive MCMAs at the medical stations. This hampered complete data collection and hence that half of the 24 patrol reports contained sufficient information for the calculation of workday rates by attendance type, which clearly reduces the power of the present study. The medical stations, largely in height and distal from a line of sight, containing general medical statements to several judges

using standardised verbal consultation, is comparatively a standardised format. Thus, a data sheet with a review of surgical problems (pending at the time during Royal Navy Periodic in-Class (RNP) patrol, the predecessor to the Vanguard Class submarine-submerged almost 30 years ago), which the authors found data collection difficult due to incomplete reports giving information of patient management (1).

Separately, dental consultation and were seemingly a high priority report at 60% of the 24 patrol reports recorded complete working information.

While such reliability is important in the responsibility of each individual MCMC, we noted that the degree of detail and interpretation of reporting improved over time with successive patrols, such that the last 17 patrol reports contained 19 data for medical post only (27%), while the first half of the 24 reports contained the majority of these (35 reports, 60%). It should also be noted however, that all of the patrol reports did specifically comment on the occurrence of significant cases during a patrol, summarising the importance of such cases in relation to their pattern of threat to patrol integrity.

Medical and dental attendance rates

The majority of the 24 reports used in calculating rates of medical intervention used the same 12 level category as given in Table 1. The most common potential and actual for dermatological and musculoskeletal complaints (106.2 and 138.2 potential per year, 108.026 and 140.263 respectively). The remainder ranged from 10.6 (skin) to 102.0 (joint) and 101

144 ft (44 m). 1100 GRT (displacement), 1000 ft (305 m) length on deck 21 ft (6.4 m), 1000 ft (305 m) beam, 16 ft (4.9 m) draft, 1000 ft (305 m) depth, 1000 ft (305 m) depth, 1000 ft (305 m) depth.

The needs of attendance by type reflect both the medical status and fitness of the population concerned, together with the environment they should live in for prolonged periods. The submarine population consists of a relatively young group of men who have undergone timed medical examinations, meet the standard requirements to serve in the Royal Navy and further training to ensure fitness to go in and live whilst confined to service in the Submarine Service. In addition, these men live and work in the unique environment of the submarine which accommodates and restricts speech, movement and behaviour, consists of mainly repetitive tasks undertaken whilst fixed spaces contain high energy of motion noise and other equipment and contact with outside them only at a clearing agents (CAG) in the air and secondary analysis equipment.

Therefore the predominance of dermalological presentations, mostly resulting from soft tissue infections and dermatitis both non-specific and contact dermatitis, together with musculoskeletal complaints, joint pain, soft tissue injuries and occasional minor fractures secondary to falls while values such as confined environment with a constant temperature to maintain between degrees of heat etc. is unsurprising. Similarly cardiovascular complaints could occur at frequently amongst this population, which is noted in the table.

The other category of presentations consisted of respiratory, general symptoms which did not comfortably occupy one of the other specific diagnostic groups, such as headache. It is also an illustration of the importance of equipment to prevent the ill-effects of confinement and treatment, no matter how minor the complaint, whilst a single and at home most would tell a doctor with over the counter preparations consistent with the civilian population. As sea

work most has a specific safety full and fitness can have a significant impact on working systems as other members of a department accept the duties left by a sick colleague. Thus the crew understand that only present with and treatment are necessary in an attempt to avoid this. This also reflects the constant availability of and ready access to the medical officer that the men onboard have, together with the significant amount of time they have to spend on the patient all experience of their symptoms.

Regarding dental attendance, the generally high percentage of dental fitness among the crew is reflected in the fact that on average there are only 50 dental cases per patrol. While maintaining dental fitness is the main dental responsibility, it falls to the medical officer to remind and encourage the crew to attend annual and pre-deployment examinations and treatment, thus potentially mitigating against the need to undertake treatment at sea for which the MOD incurs only rudimentary training.

On review of the literature, comparison of these data with other studies is problematic for a number of reasons:

It is unsurprising that due to the unique environment and population type there are very few and limited published studies. The only other review of presentation at sea was during Royal Navy submarine deployment periods was confined to surgical conditions (1). While direct comparison is difficult due to differences in data manipulation, the authors reported that the majority of the presentations were either musculoskeletal (31%), or soft tissue (29%), or skin (29%), or ear (10%). Further more, this is consistent with other studies of work of the United States Navy submarines undergoing periods which have also noted a predominance of musculoskeletal, skin and dermatological consultations (2). Interestingly, one study also reported a significant rate of respiratory problems, generally appearing later in each deployment, life and issues from personal experience and anecdotal evidence that similar presentations occur early in US, but not, and if necessary, in

reporting probably reflecty essential issues collected and analysed.

The other main HQ might be seen as comparing data between the two systems, and which is probably the greatest asset on all the projects which involve several days in reporting format, and specifically the breakdown of gross persons. One possible solution which would allow for standardised medical sections of the period report and thus a consistent and more consistent reporting format and subsequent easier data analysis would be to employ the International Classification of Diseases (ICD) onboard Royal Navy despatch submarines. We are currently undertaking a study to determine the feasibility of this approach.

The Medical Department

The senior doctors appointed to serve as MOGAs onboard SSBN submarines undertake nuclear deployment duties have various responsibilities compared not only with their civilian peers and colleagues but also others in an army medical group. They are typically young men undertaking their first post-graduate appointments with modest medical and surgical experience. Following general naval education, MOGAs receive the same training as completed by all other naval medical officers in terms specific to their responsibilities as onboard medical personnel (nuclear physics and radiation protection for respect to both the nuclear reactor and the ballistic weapons system).

However, their primary role at sea is medical, to provide comprehensive care within the confines of limited resources and facilities and without the possibility of consulting senior colleagues for advice. Their primary objective is to manage emergencies effectively onboard and thus meet the need for medical resources.

In addition, the MOGA will have several other ancillary roles and duties, such as working with watch-keeping in the control room as the Ship Control Officer of the Watch (part of the team piloting the submarine) and

the 'change of command' the emergency period etc. A MOGA's responsibilities also include the choice of the most appropriate medical facility to which the submarine will be moved or the appropriate shore hospital to which the submarine will be moved.

A MOGA's primary duty is to ensure that the crew is fit to work and that the crew is fit to work. As an officer he has additional duties to ensure that the submarine is fit to work and that the crew is fit to work. The MOGA must also ensure that the crew is fit to work and that the crew is fit to work.

As well as the MOGA, the submarine will also carry two or three medical staff, whose primary role onboard is to monitor health plus to and to provide medical support to the MOGA. This undergoes a two year emergency medical and primary care training programme in order for the recognition and treatment of simple conditions. During emergencies they will part as well supervised by the coast and airwards.

With a comprehensive laboratory and basic monitoring equipment and in the disposal of the MOGA and his or her staff onboard there are no diagnostic resources available and they must rely largely on clinical signs when assessing the severity of a case of presentation.

Medical Emergencies and Casualty Evacuation

The need of a nuclear submarine for diagnostic personnel is quite unique. The submarine will remain closed for several weeks and will not return to the surface or maintain communications in order to remain undetected. It will only receive them and they must be a trained generalist or specialist in the field. The only exception to the outstanding principle of an SSBN remaining undetected is the occurrence of emergencies at sea, which may include the occurrence of or injury to members of the Ship Company. Such a procedure is a major undertaking both

logist only and is limited to threatening the security of the ship.

In significant cases, that may potentially result in the requirement to evacuate a patient from the submarine are discussed with the Command or base. There exists a variety of criteria which determine whether or not a casualty may be evacuated. The medical criteria include threats to life, to limb or to vision, self-harm to cause permanent damage. These criteria are then further modified by the operational needs of the submarine. The detainee must continually be the Captain and the skipper of Defence. Ultimately, Command or base rules upon the recommendation of the MODSAC or MEDSAC or CASDAC of an individual.

If the criteria are satisfied and evacuation is deemed necessary, the evacuation of the MEDSAC and CASDAC procedure may take several days. In addition, the physical process of evacuation is complex and requires a team from the Ship Company to move the casualty through the confined spaces of the submarine and into a position outside the submarine (which is surfaced for extraction).

In view of the unique role of the MODSAC and his department and all the at-the-moment demanding and sometimes important aspects of the present study, continuous review of most daily urgent cases occurring at sea that warranted consideration as patient is needed by staff. We should request for further criteria if any which cases were staff daily urgent to pose a potential threat to the maintenance of patient integrity.

Patient threatened cases were seen at a rate of 3.12 per 100 000 man-days. Approximately one case every three periods (three ranged from four to six) during the course of patient integrity during out-compatibility, acute appendicitis and renal colic and acute threatening need for patient spontaneous pneumothorax and myocardial infarct.

The most common cause of concern for premonitory was the occurrence of acute appendicitis with 7 cases over 6 periods (6/66 cases per 100 000 man-days). There were 2 cases each of renal colic and myocardial

infarct (2/36 cases per 100 000 man-days). All other patient threatening conditions occurred once only (0/10 cases per 100 000 man-days).

With the numerical occurrence of patient threatening cases was not negligible, their effect on patient integrity was less dramatic. Of the significant cases recorded, only 5 (6/16) resulted in emergencies avoided on the individual from the submarine during the period. As a result, while the majority of 32% of periods was threatened by a patient medical case, only 1% of periods (1 in 10) required a MEDSAC or CASDAC. All remaining cases were successfully managed conservatively onboard in the sickbay by the Medical Officer.

Cardiopulmonary

In this study we present the first comparisons on removal of medical and dental personnel from the sea (surface) British submarines during nuclear deterrence patrols.

Over a 12-year period 76 patients were (discharged) in a total submarine deployment of 250 000 man-days. The major presentation was acute dermatological and musculoskeletal, reflecting both the nature of the personnel, their environment and occupational factors.

Patient threatening cases occurred at a rate of 1.66 per 100 000 man-days. However, evaluation staff only required 33 (1/14) of approximately 1 per 14 periods. The difference represented successful onboard management in 98% of cases.

It is interesting that perhaps worth taking a little time to reflect upon the fact that 10 (1/14) were recorded there is a submerged 10 000 ton Vanguard Class submarine on nuclear deterrence patrol carrying approximately 150 men and a MODSAC whose primary objective is to provide the safe medical care to the crew and ultimately to ensure the maintenance of patrol integrity. From our review we think it reasonable to conclude that to date such MODSACs have been very effective in ensuring that objectives supporting the requirements for their part, need appropriate to these submarines.

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Conclusions

The authors have no conflicting interests to declare.

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continuum between the Glasgow Outcome Score, a three months and the one year is transfer.

What should we do?

There will always be distinct differences between how treatment can be provided for civilian assault vs. and local (at least) both combatant and non-combatant.

Specific interventions that could or should be carried out in a deployed field hospital are contentious. This contention arises because of the results of the UK air warner which readily represent contrast with that of the local population. The level of care the local population can expect outside of the deployed field hospital may be of a very basic standard indeed this should be expected where vital fighting will destroy infrastructure and medical capability.

Some specific issues are considered below.

Intracranial pressure (ICP) monitoring. There is a clear consensus view amongst neurosurgeons that ICP monitoring is important however this is not borne out by any specific evidence (22). It is almost likely that many combat related measures of low a cause degradation in addition to Cerebral Perfusion Pressure (CPP) defined as Mean Arterial Pressure - ICPs and ICP are required to alter outcome (23). There is also evidence that maintaining ICP does not alter outcome but can increase length of stay and measure of success (24). In Connor's study two hospitals were compared. One hospital used general supportive measures and another a mean arterial pressure of >60mmHg, the other centre targeted ICP <60mmHg and CPP >60mmHg. Admissions were deemed not only by the geographical location in which the injury occurred. Outcomes were similar in both hospitals (mortality 35% vs 34%) however the primary loss the ICP targeted hospital spent 12 days on mechanical ventilation compared to 5 days at the other centre. The ICP targeted centre also used significantly more resources (mammals, perfumes and medications). This would clearly have major implications for a deployed ICU that is supporting local patients. As the optimum level of CPP is still debatable a

limited support system is recommended. ICP of >30mmHg increases the risk of death in CPP <100mmHg, at 30-40mmHg the risk of death doubles, at 40-50mmHg the risk of death quadruples, at 50-60mmHg the risk of death increases 10 fold, at 60-70mmHg the risk of death increases 20 fold, at 70-80mmHg the risk of death increases 40 fold, at 80-90mmHg the risk of death increases 80 fold, at 90-100mmHg the risk of death increases 160 fold.

The consensus that there is no data on this although ICP monitoring is an accepted standard of care in the deployed environment is valid, and the technique may be able to achieve the ICP target thresholds to maintain a cerebral perfusion pressure but quality intensive care are more important than simply monitoring ICP (25).

Hypothermia. The evidence for the therapeutic use of hypothermia is limited (26) but it works in the ICU. There are two major problems with this intervention. Firstly there is a lot of difficulty in maintaining a desired temperature in all stages of the resuscitation and especially in the current theatre of combat. The importance of this is that though changes in patient temperature can lead to a second increase in ICP which may be unrecognised if ICP is not measured. Secondly many patients suffer head injury as part of multi-system trauma and the outcome in this group related with hypothermia has been shown to be worse. Current attention is focused on preventing hypothermia in military trauma and trying to manage the coagulation hypothesis for specific cases may prove dangerous and get in the way.

At present the testing and equipment levels in a deployed ICU do not allow for complex measures of cerebral oxygenation, metabolism or even pressure monitoring. However it has been suggested that it is maybe possible to make a more opinion based system (27). An accommodation has been constructed (28). Without these the decision to intubate and then the risk benefit analysis of therapy is made difficult. What seems more appropriate is to pay attention to a more measured and accurate capabilities have aimed ICP this can allow be adjusted to some extent by CT scoring and general CTs in the local population.

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as I could. My mind was running through a check list of things to do whilst I stayed here pending the arrival and MERT prepare the casualty clearance checklist, advise the OC on the situation, return to the casualty and what else I could do?

Before I could even begin a secondary survey, I met my drugs or Oxygen carrier. I was told there was a second casualty. The delay in finding it in was because he was on the other side of the deck crossing, we all had to be secured prior to searching for it in. Leaving the first of people, I crossed the deck to find a small group of five men. It is protective ring around him. Even then I was in risk of the passing need for us to leave again. He had a head injury in with an 8cm x 4cm laceration and fractures. He was very confused and kept repeating his drawings and telling us off. I was having difficulty assessing or treating him so he would not stop telling us off. Meanwhile my CMF was shouting orders about the first casualty and I was dealing with my assignment. At the same time the OC was on the net requesting further details to go on to the Medical Emergency Response Team (MERT). It was a bit dark and with our torches we were a long target for the Taliban. The situation was deteriorating and would turn into disaster if we were engaged further. As a disposal team commander, we had to leave the scene in minutes less than 10 minutes. The MERT helicopter was already on its way and we had to be at the landing site to meet it. In the end we had the second casualty down whilst I splinted his fractures and supported his wounds. We could both support it's quickly away from the site of the explosion and loaded it into what the MERT as down broke.

As soon as the MERT I heard all I took the opportunity to reassess the man, many of whom had used their personal medical kit to help the injured friends. I was exhausted but the day was not over yet. A few hours later the Taliban engaged another Tropic, during which a sniper was severely injured in an explosion. The Tropic medic, an MA, saved his life by applying an tourniquet immediately. When the CMFs spoke around at the same time took charge and spent the casualty enough to

at a helicopter. Unfortunately whilst this remains were discussed. We splinted his legs in splints for the move. The MERT was already on its way so we loaded the patient in a stretcher and began the way to the nearby Emergency Helicopter Landing Site (ECLS). Their information came over the ICCEM scanner that the enemy had also taken with a stretcher and were about to attack. The danger was that the Taliban would attack the MERT whilst it was stationary on the ECLS. It stuck us as we carried the casualty to it. I was asked for my opinion on whether the casualty required treatment enroute from the ECLS at the Green Zone or if he could be transported to the FOB. ECLS was not more secure. With no possibility of using vehicles we would have to carry him all the way. In my mind I had to discuss the plan to the patient against the risk to the MERT crew and the rest of the Company. I had had to consider the MERT a considerable but not unknown loss. I thought quickly and advised the OC that we should carry the casualty to the FOB. As this was agreed I could only prepare myself for the demanding carry past many fields and ditches. The sun was high and I was already stretched at waist. As we got off the muddy ground added our loads in requiring effort to take each step. We took turns as porters bearing and needed to move past one other before our arms became too fatigued and we dropped the stretcher. The darkness began to fall as we did our work of all in less than 2 hours and 4 feet deep and filled in its murky water. We would pump in then balance the stretcher on ourselves and had to use the bar back to a scrambling up the other side. The heavy equipment had helped as the casualty seemed settled at each corner past its quite long, joined up in all of systems. As we reached the FOB we were still in a bit of a hurry, each only managing to turn the stretcher for medical help's change over. The rest of troop from later joined in our task, when the FOB gale opened and several men carrying casualty arrived at our side. Our last few hundred metres. They were fresh and I could barely keep up with them as they ran on to the

usually they [the F&B] did not have a medical space in which to do their job. The two tables donated for the submarine hospital at my old HMSI in the mid-1960s were by the way a great find. They were made of a good quality wood, it was said of our pump. I watched the men for signs of heat stress, knowing that I was not doing good myself. It had taken us just under an hour to complete the stretch duty. It was a day I will never forget.

Combat casualty care was provided by members of the HMSI's all over, although standing OP HARMCEB. Royal Navy MRAs and MQs provided close medical support to 2

Commando Brigades, often putting out their lungs in danger in order to bring our injured men to our colleagues. I am a little doubtful that I'd be born the hero of my successful F&B mission. Certainly we made for my ship in blood stream. Many of the MRAs I worked with had never been deployed before, yet they performed admirably in a most stressful environment. Our hospital brethren worked equally hard, attending to the ever-increasing stream of patients coming into Britain. As a result I believe we have gained a significant amount of valuable experience. The details of all which cannot be over-stated. This will serve us well in the countless deployments to come.

Dr Agnes L. Leinster PhD in Royal Navy OP HARMCEB

intravenous ketamine or intramuscular morphine and gas was administered. Hypertensive effects and other pharmacological effects of the drug were prolonged compared to the control group. No patients died. The authors concluded that ketamine could be used as an anesthetic for battlefield surgery and to relieve pain in the field. The authors also noted that the use of ketamine in the field was limited by the lack of a reliable method of administration. They concluded that ketamine could be used as an anesthetic for battlefield surgery and to relieve pain in the field. The authors also noted that the use of ketamine in the field was limited by the lack of a reliable method of administration. They concluded that ketamine could be used as an anesthetic for battlefield surgery and to relieve pain in the field.

British Army Medical Corps reported that

work as part of the field surgical team supporting the emergency operations. In October 1944, a 12-month period of field trials of ketamine was used for the daily dressing changes of 400 to 600 patients. The time taken to dress wounds using ketamine was found to be less than that using morphine and as a consequence the wounded were released by medical and surgical teams. The authors however reported that ketamine was not without complications.

The following is a list of complications reported by the authors. Ketamine was used for the treatment of pain in the field. The authors reported that ketamine was used for the treatment of pain in the field. The authors reported that ketamine was used for the treatment of pain in the field. The authors reported that ketamine was used for the treatment of pain in the field.

Table 2 - A summary of the use of ketamine through all three conflicts

Reference	Conflict/Study	Main conclusions
(11)	World War II (1944)	Use of ketamine in the field was found to be a valuable asset in the treatment of pain in the field. The authors reported that ketamine was used for the treatment of pain in the field. The authors reported that ketamine was used for the treatment of pain in the field.
(12)	Algeria (1961)	Intravenous ketamine was found to be a valuable asset in the treatment of pain in the field. The authors reported that ketamine was used for the treatment of pain in the field. The authors reported that ketamine was used for the treatment of pain in the field.
(13)	Fighting on the Thai-Cambodian border (1984)	Study involving 11 men and 1 woman reported that ketamine was found to be a valuable asset in the treatment of pain in the field. The authors reported that ketamine was used for the treatment of pain in the field. The authors reported that ketamine was used for the treatment of pain in the field.
(14)	Study: Intravenous ketamine to relieve respiratory distress (1984)	Use of ketamine in the field was found to be a valuable asset in the treatment of pain in the field. The authors reported that ketamine was used for the treatment of pain in the field. The authors reported that ketamine was used for the treatment of pain in the field.
(15)	Study: The effect of heavy passive team participation and Albuterol on the incidence of emergence phenomena (1984)	Ketamine did not produce emergence phenomena. The authors reported that ketamine was used for the treatment of pain in the field. The authors reported that ketamine was used for the treatment of pain in the field.

Reference	Case or Study	Main contribution
124	Case report: 308 Atrial flutter put into sinus rhythm with levamisole (1000 mg) (1988)	After treating 40 times as an anaesthetist, with much more paediatrics than internal medicine. Less than 1 mg/kg of levamisole was required for induction. The second dose often cleared vent tach but the third dose did not. Reported focus method.
125	Study: Intravenous potassium and levamisole are delivered continuously to the patient in a peritoneal pump (1988)	100-150 (18 patients) epinephrine (10-50) years experience about epinephrine and thyroxine in early cardiac surgery. Concluded that this technique was advantageous when stable and regular doses of drugs for 100-150 years not possible and was a simple infection and anaesthetic.
126	Casey Anesthesiology Symposium January 1989	The only person of mass described in 1971 should be immediately into the field and that should be stopped 10 minutes before the initial surgery. Concluded that possible between 2-3 minutes and the patients were awake and able to correctly answer questions by hours 33-35 minutes.
127	Case Note 1989	Used feature of technique described in 1971 to a rapid induction of sedation followed by a rapid induction of anaesthesia. Used a group of two patients undergoing internal or external cardiac surgery. A dose of 10-15 mg of levamisole followed by 10-15 mg of levamisole. Levamisole produced hypotension in 10% of induction of anaesthesia.
128	Report: Government Hospital in North Uganda in 1989	Resuscitation was a painful episode when an induction dose was administered and a maintenance infusion of 10-20 mg/kg/min maintained a combination with a premedication of diazepam, glycopyrrate and a total anaesthetic block.

In 1989, anaesthetists serving with the British Forces were trained to deliver drugs by intravenous pump (e.g. FMS (Fentanyl, Midazolam, Succinylcholine) was used to maintain the patient in a state of unconsciousness from the start to the end of the battle group and to provide a 'push' of drugs at the end of the battle group. The FMS (Fentanyl, Midazolam, Succinylcholine) was used to maintain the patient in a state of unconsciousness from the start to the end of the battle group and to provide a 'push' of drugs at the end of the battle group. The FMS (Fentanyl, Midazolam, Succinylcholine) was used to maintain the patient in a state of unconsciousness from the start to the end of the battle group and to provide a 'push' of drugs at the end of the battle group.

to and changing change was happening very rapidly particularly due to the many hours spent in the field.

On the 10th of June 1990, 150 patients were admitted to the hospital at 10.00. UGANDA as a result of the findings of the hospital group for UGANDA and for THIRTHAM (1990). 10% of these casualties required surgery within 2 hours of admission. As most of the casualties in the hospital had included levamisole, this was usually avoided as an anaesthetic agent was found. This therefore limited the use of levamisole in the hospital. Levamisole was not a problem.

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History

Sir James Lancaster the Explorer

MThompson



The Virginia Voyage of the *Discovery* (c. 1606-1607) (by J.P. 1607) (www.virginiavoyage.com)

Introduction

The discovery in 1606 of the first 'cancer-free' (benign) breast tumor in a 16-year-old girl, followed by many thousands of 'cancer-free' adult patients, has made the term 'cancer-free' popular in many circles in today's cancer world.

Unprecedented health progresser Captain Cook's South Sea Voyages and Lord Richard Mitchell's early on-war 'cancer-free' name lost a few 'Cancer-free' has been largely overlooked in the history and publications are elsewhere lost.

The 1606 voyage of the *Discovery* (1606-1607) (www.virginiavoyage.com) is a 16th-century voyage of discovery in the North Atlantic Ocean, the first voyage of the English to the North Atlantic Ocean, the first voyage of the English to the North Atlantic Ocean, the first voyage of the English to the North Atlantic Ocean.

James Lancaster

Captain Sir James Lancaster (1581-1634) was a 16th-century explorer, commander of the English explorations under sail to the East Indies and the Indian subcontinent between 1601 and

one of the groups of 15 men, arms, and provisions, and 15 ships, including 10 men-of-war, set sail for a three-year voyage north.

Lancaster's 15 ships, together with 10000 men, sailed down the English coast, and then sped in the ice towards the Canadian Arctic coast, where they spent only four or five months before returning. In 1600, the expedition was the last of its kind. The English were too busy to fight elsewhere for the next 100 years, to prevent slavery for native Americans (Carpenter 1998, pg 2). Moreover, the English sailors, although not affected by ice, for the first time, the ship voyage to the East Indies in 1591, they have had a bad day on the success of this mission. He was not alone in being forced to land on the Indian land for food, the result of the death of many of the company's stock, just before his voyage (Carter 1940, pg 10). Thus, I propose that the time had come when Lancaster should think of to measure the success of his voyage. In other words, he decided to try and reduce the risk of being seen from sailing based on a Portuguese theory that Indian gold was a prehistoric. This use of the local control groups would add weight to any conclusions drawn from this, after that, many years later, but it was probably not Lancaster's intent to conduct a scientific experiment.

The source even offers his own explanation as to why the search for better health led to a ship, which provided us with further evidence that Lancaster had access to the careful effects of lemons.

And the reason why the general men stood better in health than did the men of other ships was this. As Lancaster brought to sea with him certain bottles of the juice of lemons, which he gave to each one, so long as it would last, until afterwards every morning. By this means the general men, many of his crew, and consumed the rest. (Horn 1581-1606, pg 76)

The use of lemon juice as a cure as well as a preventive was therefore shown in this trial. Further evidence is available that shows Lancaster's knowledge of the medicinal of curvy. This again adds to the scientific

quality of Lancaster's experiments. He clearly was knowledgeable in a different theory, because he was not alone.

Knowing that the Indians and sailors had been ill, because all our diseases there, it was not impossible for us to have been ill. (Horn 1581-1606, pg 76)

Lancaster's previous trip to London had good results, as the English and Indians, because of the knowledge of the Indians, I was told at the time, the Indians had a "secret" (Horn 1581-1606, pg 76).

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The knowledge of the Indians, because of the knowledge of the Indians, I was told at the time, the Indians had a "secret" (Horn 1581-1606, pg 76).

Lancaster also managed to persuade the rest of the company of off cars that oranges and lemons were the key to cure them. It was not a full account of the voyage home. I am clear that there was no doubt about the effectiveness of the cure.

Then the Company of the West-Indies called to the general and thought it best to leave into the bay of Antwerp (on the coast of the Netherlands) and there to refresh our men with oranges and lemons, to cure ourselves of the disease, which was by him and the whole company (Horn 1581-1606, pg 80).

All four ships returned to London in 1583, fully laden with cargo from the East, and the

of a vessel's health is a high priority. Wilson and others' *Journal of the Royal Naval Medical Service* is devoted to preventing disease.

James Lind

One hundred and fifty years after James Lancaster it is a surgeon called James Lind (1708-1794) who is portrayed as a Royal Naval surgeon and his career focus on medicine is well documented (Carpenter 1986; pp 54; Harvey 1992; Thomas 1994). Not least through a re-publishing of his own treatise on the treatment of scurvy (Seawater, 1663) in its 100 years anniversary year of 1963. The treatise includes a brief description of an experiment carried out on a dozen sailors with scurvy whilst at sea (Lind, 1753). It has been widely claimed that this experiment was the first published clinical trial (Bussard 1982; Roddie 1944; pp 37) and that "Lind really led to the end of scurvy among the sailors" (Harvey 1992; p 68). In this way Lind is credited with the post mortem but could pure scurvy in fact, as told in a Short History of Naval Medicine (1994) rather than:

"Lind would be credited as the Abbot of the 18th century for such an achievement. The influence of Lind and diseases the sailor had turned on of every sailor (for proving oranges and lemons are effective against scurvy)" (Roddie 1944; pp 37).

Harvey is shown in his praise of Lind for both of these accomplishments. David Harvey has extensive knowledge of Lind's and goes on to state (Harvey 1992; pp 378) that pure Lind is "on a high pedestal. Quoted Thomas, along with others, whose knowledge of Lind as a clinical trial is credited with the discovery of a cure for scurvy as well as being the "forerunner of the modern clinical trial paper" (Thomas DP 1993).

Lind undoubtedly contributed much to the cure of scurvy. The way in which he went about his findings on the treatment of scurvy in his 1753 book is however remarkable in that it was a prelude for the conduct of a clinical trial in a documented, systematic and replicable way published before his time in a journal and after being given refereed approval by his select on medical officers.

Seawater (Lind 1753; pp 86-88) are two examples of his experiments.

On the other hand however in a well documented but for hundreds of years before Lind various nations had an idea that oranges could help with their men, such as the Portuguese and the Spaniards as shown in Carpenter's (Carpenter 1986) complete and accurate history of scurvy and its cure. It is back cited by many historians who have written on this topic (B. Hughes for example takes a more conservative and arguably more well set view).

"The use of controlled randomised of experimentation was Lind's main contribution to medical science: the demonstration that oranges and lemons cured scurvy was an apparently fortuitous suggestion" (Hughes 1975).

The famous experiment itself only occupies a very small proportion of the treatise, as pointed out by David Bussard in a letter in 1992 (Bussard 1992) and does not appear to have had much importance placed upon it by Lind himself as it was not discussed in great detail in his treatise (Lind 1753) or with much enthusiasm. This suggests that his awareness of the importance of his methodology is not as great as has been depicted in the past by a variety of historical writers (Roddie 1944; Hughes 1975; Monaghan 1994) and that early a relatively porous notion prior to the Royal Navy was actually changed to include the contribution of the cure of scurvy (Carpenter 1986; pp 68) suggesting his conclusions were not even recognised by many of his contemporaries.

Lancaster has not been widely quoted in Britain for why he supported the Lancaster sections in 1661 were an important early example of a controlled trial (Barn 1994) and has been supported by PG Ross on this matter (Richard Ross 1994). Both these writers have made only a very brief mention of Lancaster however and have ignored the fact that it is work which preceded that which Lind was in a practical way engaged upon in his book. See Desmet (1944); Surgeon Commander Alison

Book Review

Assessment in Medical Education and Training - a practical guide

Radcliffe Oxford Publications
ISBN 078-1-84610-045-9

This book is ideally placed as a reading and reference source for anyone involved in medical education. It is also a useful resource for medical students in both primary or secondary care.

It consists of a series of different chapters by eminent subject matter experts covering all areas of medical assessment starting with the fundamental principles and following through with undergraduate, postgraduate programmes, appraisal and GP training, assessment in interviewing and in the junior performing doctor. It has been very well put together and the chapters flow relevant why. Some may think it is GP heavy but that is only because of the tremendous amount of work undertaken by the RCGP in developing these

competence based assessments. The book is a comprehensive overview of medical competence with the understanding that a GP (or specialist) needs to be competent in all the relevant assessment areas. However, they discuss assessment and competence in two other domains (behaviour) in order to be complete.

I really enjoyed this book. Having worked in a range of medical education environments (including postgraduate), it will be a useful reference source for all medical students using BlackCamp. And it will also aid in the wider learning of practice, self-reflection, information about the changes brought about at all levels of medicine through FMEPS and Modernising Medical Careers. The book itself is relatively short and easy to get through, providing a comprehensive understanding of the background behind new assessment systems. It is equally possible to dip in and out of it and to use it as a reference. I have not, but would very much like to have been in a position I would have bought it myself.

David Green

Service News

Honours, Awards and Citations

Operational Honours (Afghanistan) September 2002

Surgeon Lieutenant Henry Gouden Royal Navy
Member of the Order of The British Empire

Lieutenant Commander Alison Joyce Halfon
ANMC Queen Alexandra's Royal Navy
Nursing Service
Royal Fleet Dock

Medical Assistant, Corps 1 Kate Louise Newson
Military Cross

Leading Medical Assistant Richard Hughes
Member of the Order of the British Empire

Awards

Surgeon Lieutenant Commander A Wright
Royal Navy
Alfred Heat Medal of Peace

PROMOTION

Acting Surgeon Commander to
Surgeon Commander

Acting Surgeon Commander R A Miller
Royal Navy

Acting Surgeon Commander J J Matthews
Royal Navy

Surgeon Lieutenant Commander to
Surgeon Commander

Surgeon Lieutenant Commander D M Coffey
Royal Navy

Surgeon Lieutenant Commander A R L Allcock
Royal Navy

Surgeon Lieutenant to Surgeon
Lieutenant Commander

Surgeon Lieutenant M Teal Royal Navy

Surgeon Lieutenant C Holmes Royal Navy

Surgeon Lieutenant A Morris Royal Navy

Surgeon Lieutenant K Rahn Royal Navy

Surgeon Lieutenant A Wrigley Royal Navy

Surgeon Lieutenant D Langmore Royal Navy

Surgeon Lieutenant E Barnard Royal Navy

Surgeon Lieutenant S Gaddale Royal Navy

Surgeon Lieutenant D Porter Royal Navy

Surgeon Lieutenant D Roscoe Royal Navy

Surgeon Lieutenant M D Sney Royal Navy

Surgeon Lieutenant D Kitchin Royal Navy

Surgeon Lieutenant B Waller Royal Navy

Presentation of Medals

Institute of Naval Medicine



On the left: Mr. J. H. Smith, Secretary of the Institute of Naval Medicine, presenting a medal to Mr. J. H. Smith, Secretary of the Institute of Naval Medicine.

On the right: Mr. J. H. Smith, Secretary of the Institute of Naval Medicine, presenting a medal to Mr. J. H. Smith, Secretary of the Institute of Naval Medicine.

young Medical Assistant (M.A.) presented with a Certificate of Appreciation from the Institute of Naval Medicine.



Herbert Lott Efficiency Award



Dr John G. Campbell, Director of the Royal Naval Medical College, presenting the Herbert Lott Efficiency Award to Mr John G. Campbell.

During the ceremony, Mr Campbell presented the award to Mr John G. Campbell, who had been awarded the award for his services to the Royal Naval Medical College.

Dr Campbell presented the award to Mr John G. Campbell, who had been awarded the award for his services to the Royal Naval Medical College.

and combined) since 1997 is credited a number of First World War medals. Mr Campbell is a member of the Royal Naval Medical College and has been in a position of responsibility since 1997. He has been in a position of responsibility since 1997. He has been in a position of responsibility since 1997.

Mr Campbell is a member of the Royal Naval Medical College and has been in a position of responsibility since 1997. He has been in a position of responsibility since 1997. He has been in a position of responsibility since 1997.

During the ceremony, Mr Campbell presented the award to Mr John G. Campbell, who had been awarded the award for his services to the Royal Naval Medical College.

Blood Red Dinner 2009

Speech given by Surgeon Rear Admiral P J Raffalli DPM BSc MSc
MBCB MRCP FRCP

Your Royal Highness, honoured guests, ladies and gentlemen

This is not the night for long speeches. When Fleet Surgeons A B ELANGART and J E LUND THOMAS last convoked the edge of a Royal Naval Medical Dinner while on the Royal yacht VICTORIA & ALBERT I am sure I am proud was to bring together the band of brothers who wear the Royal Naval Medical Officers of the day to share their experiences in a formal atmosphere rather than to be subjected to extended speeches. An interest with varying degrees of success through the years – and I include myself as a previous offender.

This first dinner was held in the Osborne restaurant in London in January 1968 bringing 19 Royal Surgeons with the Editors of the BMJ and the Lancet to guests.

The first dinner again gained by a Royal presence was in 1974 when the guest of honour was His Imperial Highness Prince Louis of Battenberg and we first had the privilege of holding the dinner in the Royal Naval College, Greenwich in 1983 when some 250 members and guests were present.

Over this years the Royal Naval Medical Club has opened its doors to members of officers in the RNMOC, Regular and Reserve working together and we have granted honorary membership to those have served our patients as we well including some of our civilian consultant advisors. We are now 400 hundred strong brought with all groups represented and I am delighted to see you all here on this our anniversary year.

This has been simply splendid evening and would like to thank firstly, and the staff of the (R) Naval College, Greenwich for looking after us so well with a great dinner I thank you to her (The Lady the Marquis) and the Executive Head

Chai Lee Thevet

We thank the RNMOC Secretariat for the exceptional Chair of Deans and welcome from the Band of Her Majesty's Royal Marines. Doringwood who have not only ensured us so well to a great night – and there is more to come – but who are truly our comrades in arms deploying with us to great effect in support of our patients.

And I would also like to thank the members of the committee for all their efforts in organising tonight and I must single out Lt Col Roy Mawer my who has borne the dining and organising loads behind the scenes and who will I trust no doubt look back on his time as secretary of the RNMOC with pleasure and no little relief.

Turning to our guests, the extended and ongoing pace of operational activity has meant that there has rarely been a time when there has been such a focus on the Medical Services – and the RNMOC have delivered magnificently. This time has been achieved during a period of substantial change owed much to the leadership from Lt General Robert Barker – Deputy Chief of Defence Staff (Health) and Lt General Louise L. Birch as the Surgeon General. Thank you for joining us tonight.

And although they will be far from many of you, I am also delighted to welcome in their new positions Major General Michael Barlow, Deputy General James Marshall, Sir Peter, Air Vice Marshall Paul Evans, Commander of the Joint Medical Command and Air Vice Marshall Chris Morgan, Assistant Chief of Staff (Health) and Deputy General Medical Services (HMA). I look forward to continuing the work as they all in a most challenging and exciting time.

And finally, I am most enormously grateful that Her Royal Highness, the Duchess, of

Throughout my career I will have had many different mentors and role models. As the youngest officer and young doctor in my wing, responsibility of mentorship was placed on me from the start. I have been very fortunate to have had a number of mentors, but I would like to thank one in particular who

throughout my tenure as Medical Officer at General Hospital.

I would like to say the members of the Royal Naval Medical Club in Haid and Haid are great.

D. J. Durrin

Blood Red Dinner 2009

Responses by Lieutenant General L. Lillywhite MBE OHS MB BCH MSc psc

I have the honour as an Army Officer to stand before you in followed Royal Navy for over the first Army Officer to do so in more than 10 years. Given the outstanding support that you have provided to our operations, it is a privilege to stand before you. I am an Army Officer who should thank the Royal Medical Service for all that they have done, but more of this later. For I am not here to praise the Royal Navy, I should like to highlight the fact that the RN is involved in operations over the night.

- As a Primary Commander with the Standing JCTO Maritime Group.
- On board an anti-air and anti-submarine and smuggling operations.
- On board a Royal Naval detachment to the United States and Far East.
- Supporting the Iraq War and the US Navy.

The ability of our groups from overseas operations, Iraq and Afghanistan, to the United States is a truly remarkable feat. I am not only a British, we face the same and challenges, but to go to the sea, and that is a truly remarkable feat. I am not only a British, we face the same and challenges, but to go to the sea, and that is a truly remarkable feat. I am not only a British, we face the same and challenges, but to go to the sea, and that is a truly remarkable feat.

On 10th November 2009, I will be going through a final review, which will include a final review of the Royal Naval Medical HQ in Haid. I am not only a British, we face the same and challenges, but to go to the sea, and that is a truly remarkable feat. I am not only a British, we face the same and challenges, but to go to the sea, and that is a truly remarkable feat.

leaving, want to say and I am glad to say that I am not only a British, we face the same and challenges, but to go to the sea, and that is a truly remarkable feat. I am not only a British, we face the same and challenges, but to go to the sea, and that is a truly remarkable feat.

But let me return to the Royal Navy, and here it is appropriate to return to the fact that the 2nd Medical Division has been part of the JCTO. In 2008 the House of Commons Defence Committee gave a list of our operations, and the year the Royal Navy. The House of Commons gave the list of our operations, and the year the Royal Navy. The House of Commons gave the list of our operations, and the year the Royal Navy.

We found the standards of our operations and the Royal Navy. We found the standards of our operations and the Royal Navy. We found the standards of our operations and the Royal Navy. We found the standards of our operations and the Royal Navy. We found the standards of our operations and the Royal Navy.

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Royal Naval Medical Service Medal Parade 10 July 2009

by M Phillips

The Medical Director General (MAG) hosted a Medal Parade for the members of the Royal Naval Medical Service who had deployed on Operations between January 2008 and 10 July 2009 at HMS EXETER on 10 July 2009. The Guest of Honour for the Parade was our Commodore-in-Chief, Her Royal Highness, The Duchess of Cornwall.

Background

The RNMSS contributed to the Global Operations requirement had seen the RNMSS build the Joint Force Medical Group in Helmand Province, Southern Afghanistan during Operation HERRICK from December 2006 to April 2008. During this deployment the Joint Medical Group comprised some 547 personnel from 104 different units of which 262 are from the RNMSS. This deployment is believed to comprise the largest deployment of RNMSS personnel since the Falklands Campaign of 1982. RNMSS personnel were divided between the Headquarters and Squadron Group, the

Hospital Squadron and the Close Support Squadron. The Hospital was based in Camp Bastion and at a given time it became one RNMSS personnel in the Close Support Squadron provided medical support to 10 Forward Operating Bases throughout Helmand Province, including packing and providing trauma care at the point of wounding. At the time the RNMSS had provided 681 personnel to Operation TELIC in 2008, principally operating within the deployed Hospital in the Contingency Operating Base in Southern Iraq.

The Parade

Some 347 personnel were on Parade and included 285 members of the RNMSS (144 to Reserves and Royal Marine Medical Aid) and 63 members of the RN Logistic Warfare Group who are Reserves. 4 Royal Marines from Medical Squadron, Commando Logistic Regiment, Royal Marines 3 RN Chaplain, 3 Defence Medical Services (DMS) and



On Parade



Medal Award Ceremony



Left: Jack King, Jimmy G. (middle) and
Sgt. (middle) and Sgt. (right) in uniform.



Left: Jack King, Jimmy G. (middle) and
Sgt. (middle) and Sgt. (right) in uniform.



Left: Sailors in uniform marching in a parade.

Future Events

Primary Care Symposium (GP and OMS)
25-27 April 2000

**Combined Services Orthopaedic
Society Conference**
16 May 2000

Spit Symposium 2000
17 and 18 June 2000

MDOPM Symposium
23 and 24 June 2000

In order to expedite submission of our articles, *Journal* it has been agreed that we will publish the manuscript contents pages.

Journal of the Royal Army Medical Corps

Volume 155 No 1

March 2009

Editorial	Military professional care: why is it different? T J Hodgson, P P Ashworth A commentary from our far one troop to care R Patten A military commentary I deserve
Original Papers	Perceptives analysis of the coping strategies of male British Army soldiers with peripheral cold weather injury J E Burgess, P MacIntyre Pericliminal pain group (PPG) – a review of the first 100 patients to complete the course at the regional rehab station and Glastonbury M J Ash & UK Armed Forces Veterans and Veterans Inquiries T Jansz, J E MacIntyre Trauma & quadriceps muscle tears among Israeli Special Forces soldiers T Mizrahi, D Shikler, E Shikler, J M D'Almeida, J Caplan The Rums Run Golf N. Greenwood, R Dobbie
Case Reports	Case Reports Percutaneous medical therapy for removal of a casted, intra-articular foreign body fragment: a review J Jansz, P MacIntyre Podiatric injury due to a hand held fire – an ongoing risk? E MacIntyre, J Giff, J Patten, P MacIntyre, P MacIntyre
Brief Assessment	Physical Medicine M. Baker
Medical Military Reviews	War in Burma – Ferdinand Simon LeQuere P H Saxton
Focus on Fife	Foreword H J McCarty Five Years – An Army in Counting to Burma J Lister, D Aldington What is the dead one troop all about? – a questionnaire study J E Smith, R Patten, P P Ashworth, T J Hodgson British Military Use of Alcohol: A Historical Review C. Evans, J Giff, D Aldington Field Hospital Analysis D J Doran, J E Patten, D J Aldington Continual Physical and Mental Health in DP HERBICE B J Hughes, D. Giff Pain Management in Pain & D. Edwards, M. Edwards, D. Aldington Pain Management During Royal Air Force Strategic Aeronautical

Reviews: J. Jayatil, R. Smith, D. Aldington

1. *U.S. Combat Casualty Care: A Re-evaluation after Combat-related Trauma*
B. Jayatil, D. Aldington
Military Clinical Team Management (J. Jayatil, M. Davies, D. Aldington)

Book Reviews

Psychological Treatment of Health Anxiety & Hypochondriasis: A
Biopsychosocial Approach J. S. Abramowitz, A. E. J. B. Westbrook
George S. Yarnes - Lecturer and Professor, Surgeon, Reynolds Heart
Emergency, in Clinic of Surgery, C. Callaghan, J. A. Bradley, C. J. F. Watson

Campaign Medal

1999 Medal 1822-09

Letters to the Editor

Isolated orbital wall blowout fractures due to primary blast injury
J. D. Smith, M. O'Neil, A. Monaghan, A. J. Gibbons

**Footprints &
Experiences**

Field training in Great Britain by Lt. Col A. Low, RANMC, E. A. Cameron

a Lieutenant of Engineers Corps. Our girls 24 years, were in O in December as Consistent Associates at in Port, Malta, Gibraltar, Healer and Plymouth and MDC of Hester and Plymouth. He fought successfully to delay the closure of the latter.

In the 60s Jim Cos Tony Russell Peter Nichols Mike Hester David Ward others received the recognition of seeing the profile of anaesthetists and intensive care in the Services and the Society of Naval Anaesthetists (SONA) was formed and continues today. During the Falklands Conflict he had the important role of Director of Medical Personnel at the HQOD. He was promoted Surgeon Rear Admiral in 1985 in charge of Support Hospital Services and was also head Queens Hospital Surgeon. His last

appointment was as Deputy Surgeon General and Medical Director General (MAG) and was made Commander of the Order of the Bath for services to OMS on his retirement in 1993.

During his retirement David worked in the London from the Cancer, supported by 1 along spare, watching growth and horse racing and spending time in the job of Wright, whom he and Caroline selecta had been many friends. He was a charming man, large, affable, unassuming and a consummate professional and close friend. He is ill by widely missed.

He is survived by his wife Caroline and by his first wife, Sheila, the 4 children Christopher, Robert, Susan and Michael.

Camden Aldershot

Notice has been received of the death of the following:

Surgeon Christopher J M Adams Royal Navy

Surgeon Christopher L M King Royal Navy

Surgeon Lieutenant Geoffrey M Houghton Royal Navy

Surgeon Commander A Gifford VRD Royal Naval Reserve

The editor would welcome any words in memory of them

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